Patient Name: _____

Brisbane Smiles

DENTAL AND MEDICAL FORMS

PRIVATE AND CONFIDENTIAL

Your rights as a patient are detailed in Our Charter of Patient Rights

Available online at www.brisbanesmiles.com.au

brisbanesmiles

PERSONAL INFORMATION

We welcome you to Brisbane Smiles! We ask you to provide the following information to help us provide you with appropriate dental care,.

Title: Dr Mr Mrs Ms First Name _____ Surname_____ _____

Preferred Name _____ Date of Birth _____

Home Address: _____ Suburb & Postcode__ _____

Phone – Mobile _____ Phone - Other _____

Email _____ Name of person responsible for payment of fees _____

Your email may be used for direct contact regarding appointments, treatment and other purposes including marketing. You may opt out of direct marketing at any time by notifying our practice in writing.

Which is the best contact method to contact you? (please circle) Mobile Call Other Call Mobile SMS Email

Place of Employment _____ Your current Health Fund (if any)_____

In Emergency, Next of Kin Name: _____ Next of Kin Phone: _____

How did you find us?

- ❑ Existing Patient or Previous Patient of the Brisbane Smiles/Smile Artistry
- ❑ Family or Friend. *So we can thank them, who?* _____
- ❑ Community Involvement Which event of group? _____
- ❑ Website
- ❑ Social Media *Circle* Facebook Instagram Twitter
- ❑ Google search W*hat was your search?:* _____
- ❑ Billboards and Signs
- ❑ Radio and Television
- ❑ Newspaper and Magazines
- ❑ Other Sources *Please provide further information:* _____

Are you from a different cultural or linguistic background? Yes ☐ No ☐

Are you of Aboriginal or Torres Strait Islander descent? Yes ☐ No ☐

What is the main purpose for your visit today? _____

_____

_____

During your Treatment at Brisbane Smiles we will make use of Digital Photography. These photos are stored in our network. Brisbane Smiles may use non-identifiable copies of 'before' and 'after' photos for patient resource material and for advertising purposes. Should any identifiable (Face) shots be used, Brisbane Smiles will first gain your verbal and written consent. All photos of teeth and smiles remain the property of Brisbane Smiles and are not transferrable to other Dentists.

Initials _____

Date _____

Thank-you for choosing Brisbane Smiles to consult regarding your smile. We are committed to your treatment being personalised.

FULL PAYMENT IS DUE AT THE TIME OF TREATMENT.

WE ACCEPT HICAPS, CASH, EFTPOS, ELECTRONIC BANK TRANSFERS (in advance) AND CREDIT CARDS.

Please view some important Practice Policies and initial the adjacent area,	Please Initial
PRIVACY POLICY Our full policy is available at https://www.brisbanesmiles.com.au/privacy-policy/ and also available printed in our reception. We will collect Personal Information and store your Personal Information in accordance with our Privacy Policy and take all reasonable measures to protect the information from misuse or loss. Your personal information will only be discussed with yourself or guardian. If we need to, we primarily use email to send referrals to Specialists or other Dentists. Emails are not as secure as collecting any information in person or via registered post. We send your personal information in a password protected pdf attachment in the email. We do not take responsibility for emails upon leaving our outbox.	
DENTAL FEES Full payment at the time of treatment is required regardless of health fund cover. Our practice is committed to providing you with the best treatments and we charge what is usual and customary for the service. You will be informed of fees before your treatment begins. It is your responsibility to discuss any financial concerns you have before your treatment is commenced.	
CHANGING APPOINTMENTS To ensure we run on-time for your appointments and the appointments of our other patients we appreciate at least three business day notice to change your appointment time. If you are late to an appointment, your appointment may be rescheduled and a fee charged. If you miss an appointment a fee will be charged and future appointments will require full non-refundable pre-payment before booking. We DO NOT CHANGE APPOINTMENTS VIA EMAIL	
TREATMENT CONDITIONS Mobile Phones, Tablets, Ipads, Photographic or video cameras are not to be used in our surgeries. Please turn all devices off before entering the surgery.	

CONSENT TO PROCEED

Thank-you for understanding our Practice Policies. Please accept these policies below.

Name of Patient (Please Print) _____

Signature of Patient or Responsible Guardian _____

Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury _____ ☐ ☐
2. an allergic or bad reaction to any of the following: ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ chlorhexidine (CHX)
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex _____
   - ☐ nuts _____
   - ☐ fruit _____
   - ☐ other _____
3. heart problems, or cardiac stent within the last six months _____ ☐ ☐
4. history of infective endocarditis _____ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) _____ ☐ ☐
6. pacemaker or implantable defibrillator _____ ☐ ☐
7. orthopedic implant (joint replacement) _____ ☐ ☐
8. rheumatic or scarlet fever _____ ☐ ☐
9. high or low blood pressure _____ ☐ ☐
10. a stroke (taking blood thinners) _____ ☐ ☐
11. anemia or other blood disorder _____ ☐ ☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____ ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____ ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____ ☐ ☐
15. asthma _____ ☐ ☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus)___ ☐ ☐
17. kidney disease _____ ☐ ☐
18. liver disease _____ ☐ ☐
19. jaundice _____ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency _____ ☐ ☐
21. hormone deficiency _____ ☐ ☐
22. high cholesterol or taking statin drugs _____ ☐ ☐
23. diabetes (HbA1c = _____) _____ ☐ ☐
24. stomach or duodenal ulcer _____ ☐ ☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____ ☐ ☐
26. osteoporosis/osteopenia (e.g., taking bisphosphonates)_____ ☐ ☐
27. arthritis _____ ☐ ☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)_____ ☐ ☐
29. glaucoma _____ ☐ ☐
30. contact lenses _____ ☐ ☐
31. head or neck injuries _____ ☐ ☐
32. epilepsy, convulsions (seizures) _____ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) _____ ☐ ☐
34. viral infections and cold sores _____ ☐ ☐
35. any lumps or swelling in the mouth _____ ☐ ☐
36. hives, skin rash, hay fever _____ ☐ ☐
37. STI/STD/HPV _____ ☐ ☐
38. hepatitis (type ____) _____ ☐ ☐
39. HIV/AIDS _____ ☐ ☐
40. tumor, abnormal growth _____ ☐ ☐
41. radiation therapy _____ ☐ ☐
42. chemotherapy, immunosuppressive medication _____ ☐ ☐
43. emotional difficulties _____ ☐ ☐
44. psychiatric treatment _____ ☐ ☐
45. antidepressant medication _____ ☐ ☐
46. alcohol/recreational drug use _____ ☐ ☐

ARE YOU:

47. presently being treated for any other illness _____ ☐ ☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)_____ ☐ ☐
49. taking medication for weight management _____ ☐ ☐
50. taking dietary supplements _____ ☐ ☐
51. often exhausted or fatigued _____ ☐ ☐
52. experiencing frequent headaches _____ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco _____ ☐ ☐
54. considered a touchy/sensitive person _____ ☐ ☐
55. often unhappy or depressed _____ ☐ ☐
56. taking birth control pills _____ ☐ ☐
57. currently pregnant _____ ☐ ☐
58. diagnosed with a prostate disorder _____ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)** 

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]_____ ☐ ☐
2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had complications from past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?_____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
20. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?_____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____