Patient Name: _____

Brisbane Smiles

DENTAL AND MEDICAL FORMS

PRIVATE AND CONFIDENTIAL

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

Available online at www.brisbanesmiles.com.au

11/2021

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?

- ❑ I am an Existing or Previous Patient
- ❑ Family or Friend. *So we can thank them, who?* _____
- ❑ Community Involvement Which event of group? _____
- ❑ Website
- ❑ Google search W*hat was your search?:* _____
- ❑ Social Media *Circle* Facebook Instagram Twitter
- ❑ Billboards and Signs
- ❑ Radio
- ❑ Television
- ❑ Newspaper or Magazine
- ❑ 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 digitally. 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 check with you. All photos of teeth and smiles will generally not be transferred to other Dentists unless clinically relevant.

Your Initials _____

Date _____

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PERSONAL INFORMATION

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 a program Mediref to send referrals to Specialists or other Dentists. This program sends time-limited, encrypted links via email for download of your referral records and the link can be removed at any-time. Emails are not as secure as collecting any information in person or via registered post. 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. Treatment cannot be provided to patients with accounts owing. 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. **Larger treatments may require Deposits and Pre-payments. If payments are not made as required, appointments may be cancelled.**	
CHANGING APPOINTMENTS To ensure we run on-time for your appointments and the appointments of our other patients: **Changing Times** – We are more than happy to change Appointments with at least 3 business days' notice. **Late Arrival** - Your Appointment may be rescheduled and a fee charged. **Late Changes/Missed Appointments** - A fee will be charged. If you wish to book future appointments a full, non-refundable pre-payment will be required before booking. **We DO NOT CHANGE APPOINTMENTS VIA EMAIL, Please call (07) 38703333 for Appointment Changes.**	
TREATMENT CONDITIONS No photographs or videos are to be taken within Brisbane Smiles without our prior written consent. 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.**	
COVID-19 AND DENTAL CARE We Thank you for your patience throughout the Covid-19 period. Dental Care is under high demand and it is our priority to ensure you receive timely and safe care. Up-to-date information regarding Covid-19 and Dentistry can be found here: www.brisbanesmiles.com.au/condition/covid-19-and-dentistry WE ASK YOU TO KINDLY DEFER YOUR APPOINTMENTS IF YOU HAVE ANY COVID-19 SYMPTOMS, ARE UNDER QUARANTINE RESTRICTIONS, OR HAVE A FEVER. THESE CONDITIONS WILL CHANGE DEPENDING ON LOCAL RISK FACTORS AT TIME OF APPOINTMENTS AT THE DISCRETION OF TREATING PROVIDERS. Symptoms of Covid-19 include Fever, dry cough, Shortness of breath, chest pain, sore throat, loss of taste/smell.	

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) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ 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 or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, 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 (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
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) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
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 (e.g. Alzheimer's disease, dementia, 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 or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
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, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
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, vitamins, and/or probiotics 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

Patient 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, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing?	☐	☐
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, or can you see more of the roots of your teeth?	☐	☐
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 try to 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 mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) 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 _____