Melbourne Smile Clinic

Welcome to the Melbourne Smile Clinic

To assist us in providing the best dental treatment for you, please answer the following questions as completely as possible

Personal information

First name: Mr Mrs Ms Dr_____ Last name: _____

Street Address: _____ Date of Birth: _____

Suburb/Town: _____ Postcode: _____

Telephone (Home):_____ Mobile: _____

Telephone (Work):_____ Email: _____

Occupation: _____

Name of person responsible for fees: _____

Address (if different from above): _____

Who/What referred you to our dental practice?_____

Do you have private dental health insurance? Yes/ No

Name of fund: _____

Notice to insured patients regarding dental benefits insurance.

Item numbers on our statement represent as accurately as possible the procedures performed but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient or of the procedures to attract refunds and the rates of those refunds are determined by the patient's insurance policy. We accept no responsibility to either party, for any decision the Insurer may make regarding the refund monies to the patient.

Medical Information

Name of medical doctor:_____

Medical Practice Address:_____Postcode:_____

Telephone:_____

Have you had any or are suffering any of the following (Please tick):

Arthritis/Rheumatism		Heart condition/murmur	
Artificial Joints		Hepatitis/Liver disease	
Asthma		Kidney disease	
High/Low blood pressure		Osteoporosis or other bone disorder	
Cancer/Tumour/other malignancy		Radiation or chemotherapy	
Diabetes		Rheumatic fever	
Emphysema or other lung disease		Special Needs (e.g. autism)	
Epilepsy		Stroke or other CVA	
Excessive Bleeding		Tuberculosis	

Have you had any other previous illnesses? Yes/ No (please list):_____

Are you a smoker? Yes/ No

Are you pregnant (for women)? Yes/ No Due date(if expecting):_____

Have you ever been advised to take antibiotics before dental treatment? Yes/ No:

Are you taking any medications (prescribed or not)? Yes/ No (please list):

_____

Do you have any allergies? Yes/ No (Please List):_____

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Dental History

Are you interested in teeth whitening? (please circle):		Yes	No	
Are you interested in teeth straightening? (please circle):		Yes	No	
Teeth missing (Y/N)?	If so, how many?			
Which teeth?	Any gaps?			
Please circle where appropriate:	Implants	Dentures	Bridge	
Number of fillings (please circle):	0	<10	<20	20+
If you have had fillings completed previously, what type were they? (please circle): Amalgam (metal)		Composite (white)	both	
Have had any other treatment? (Please circle):		Crown	RCT	
How long were these treatments completed?				
Any Dental specialist treatments in the past?	Perio	Endo	Ortho	Oral surg.
Do you have cleans' regularly? (Y/N):				

1) How often do you floss your teeth? (Please tick)

- ❑ Once a day
- ❑ Twice a day
- ❑ More often
- ❑ Less often
- ❑ Do not floss

2) Are you happy with your smile? On a scale of 1-10 if you do not rate your smile as 10 (perfect) what would you most like to improve?

_____

3) What kind of toothbrush do you use? (Please tick)

❑ Manual toothbrush	❑ Soft bristle
❑ Electric toothbrush	❑ Medium bristle

Patient Signature

_____