# Welcome to Clear Dental Practice

Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you. All information will be treated with complete professional confidentiality.

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr (please tick)

Surname ____ Initials ____ Preferred 1st Name ____

Date of Birth ___ / ___ / ___

Home Address ____ Postcode ____

Business Address ____ Postcode ____

Home No. ____ Business No. ____ Mobile No. ____

Occupation ____ Employer ____

Email address ____

What Dental Insurance do you have? ____

Who recommended you to this practice? ____

## MEDICAL HISTORY

Do you, or have you had any of the following? (please tick)

| | | | |
|---|---|---|---|
| ☐ Heart Murmur/Artificial Heart Valve | ☐ Hepatitis A / B / C | ☐ Lung Problems | ☐ Radiotherapy |
| ☐ Heart Attack or Heart Operation | ☐ High or Low Blood Pressure | ☐ Kidney Problems | ☐ Chemotherapy |
| ☐ Angina | ☐ Bleeding Disorders | ☐ Epilepsy | ☐ Osteoporosis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ Tuberculosis | ☐ Other health problems *(please list in box below)* |
| ☐ Hip, Knee or other Artificial Joints | ☐ Asthma | ☐ Anxiety/Depression | |

____

Do you have any Allergies? ☐ No ☐ Yes ____

Are you currently receiving any Medical Treatment? ☐ No ☐ Yes ____

Are you presently taking any Medication? ☐ No ☐ Yes (please list) ____

____

Are you a regular smoker? ☐ No ☐ Yes - How many cigarettes per day? ______________

Ladies, is there a possibility you may be pregnant? ☐ No ☐ Yes

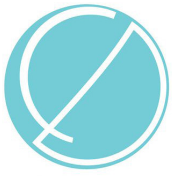
AIDS (HIV Virus) and HEPATITIS are infectious and can be present in Human Body Fluids
Are you, to your knowledge in a high risk category for either of these viral infections?

☐ No ☐ Yes ☐ Unsure how to Answer

Would you like to discuss any aspect of your Medical History with the Dentist in private? ☐ No ☐ Yes

Name of Medical Practitioner ____ Phone No. ____

Please turn the page over and complete the back of this form also




# DENTAL HISTORY

What is the reason for your visit today?

How long since you last saw a dentist?

How long since your last dental X-rays?

Do you feel that you grind your teeth? ☐ No ☐ Yes

Do you wake with a sore/tired jaw? ☐ No ☐ Yes

Does your jaw click? ☐ No ☐ Yes

Do you have worn, uneven edges on your teeth? ☐ No ☐ Yes

*If yes, do these bother you?* ☐ No ☐ Yes

Do you have chips on your teeth that bother you? ☐ No ☐ Yes

Do you have spaces that bother you? ☐ No ☐ Yes

Do you like the colour of your teeth? ☐ No ☐ Yes

Do you feel nervous about having dental treatment? ☐ No ☐ Yes
If so, what is your biggest concern?

Have you ever had an upsetting dental experience? If yes, please describe: ☐ No ☐ Yes

How would you rate your smile on a scale 1-10?
*(with 10 being the highest)*

If not 10, please comment below on how we can help make it a 10 or anything else that you feel is important.

How would you improve your smile? ☐ Colour ☐ Add Length ☐ Add Width ☐ Shape ☐ No Change

How often do you brush your teeth? ☐ Once a Day ☐ Twice a Day ☐ Three Times a Day

Do your gums bleed or hurt? ☐ No ☐ Yes

Do you floss? ☐ Everyday ☐ Occasionally ☐ Never

Have you ever been diagnosed with gum disease/loose teeth? ☐ No ☐ Yes

Have you noticed any mouth odours or bad tastes? ☐ No ☐ Yes

Do you use an electric toothbrush? ☐ No ☐ Yes

Would you consider cosmetic dentistry? ☐ No ☐ Yes

I hereby certify the information supplied above to be true and correct. I authorise doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of dental needs.

Signature: .................................................................................................................. Date: ...................................................
(If under 18, parent/guardian)