

WELCOME TO OUR OFFICE!

GENERAL INFORMATION

Surname: Title (e.g. Mr/Mrs/Ms/Dr etc).
Other names. Date of Birth.
Home Address.
..... Post Code.
Business Address.
..... Post Code.
Phone (H). Phone (W).
Phone (Mobile). Email address.
Who can we contact in case of emergency or urgency.
What is their phone number. Your relationship to them.
Name of person responsible for payment of fees.
Address of this person (if different from above).
.....
Who recommended us to you?

MEDICAL HISTORY

Do you have a current medical problem? What is it?
Are you taking any drugs or medications? What kind?
If female, are you pregnant?
Have you ever had any of the following?

	Yes	No		Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Ailment	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>
Stomach / Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>

Please elaborate on any "Yes" answers.
.....
.....

Is there anything you would like to discuss in private with the dentist?

I have completed this questionnaire to the best of my knowledge and understand that failure to make full disclosure may place me at undue medical risk.

Signed. Date.

**On future visits it is very important that any changes to the above history be advised.
Thank you for your cooperation.**

DENTAL HISTORY

This next section is to help us better understand what you would like for yourself as far as your teeth, oral health and appearance are concerned.

What is the reason for your visit today?
When was your last visit to a dentist?
What was done then?
Do your gums bleed when you brush? Is this is normal and healthy?
Does food catch between your teeth? If yes, where?
Are you aware of having bad breath?
Have you had orthodontic treatment? When
Do you feel there is always something going wrong with your teeth?
If yes to the above, is it decay, teeth breaking or something else?. Please specify on next line
.....
Do you expect to end up with dentures?
If yes to the above, would you prefer to keep your teeth?

Do you clench or grind your teeth?
Do you get headaches? How often?
Do you get neckaches? How often?
Do you get backaches? How often?
Do you get pain or soreness in the face or around the ears?
Does you jaw click or crunch when you open or close your mouth?
Is it hard for you to open your mouth really wide?
Have you had teeth break in the past or present?
Are you missing any teeth? How many?
If yes, have you had them replaced?

Do you like the colour of your teeth?
Would you like any information on tooth whitening?
Are your teeth wearing away or chipping?
Are your teeth crooked or misaligned anywhere?
Would you like to have straighter teeth or a straighter smile?
Do you have any gaps in your teeth which you would prefer not to have?
Do you have dark or black fillings in your teeth?
If yes, do these show through the enamel of your teeth making them look dark?
If you have fillings in the front teeth, do these still match your teeth or have they become darker or discoloured
ie?



If the tooth fairy could wave a magic wand what would you like to change about your mouth or teeth or smile?

.....
.....
.....
.....

PRESENT HEALTH CARE PROVIDERS

In order that we may be more effective in helping you, please write down the names and addresses of your health care providers. Please include the names of your medical practitioners, chiropractors, naturopaths, homeopaths etc.

Name..... Phone
Address
.....

Name..... Phone
Address
.....

Name..... Phone
Address
.....

PRIVACY INFORMATION

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1998

Our practice, as in the past, respects your right to privacy. We encourage you to understand why we collect details about your health, how we use this information and who we share it with. Our policy is as follows.

- 1. The information is used to help provide treatment to you. Personal information such as name and address is used for accounts, receipts as well as contacting you about other issues affecting your treatment with us.*
- 2. We may disclose your health information to other health professionals, or ask about it from them, if, in our judgement that is necessary in the context of your treatment. For example, if we were to refer you to a specialist for an opinion about some matter we would advise the specialist of any relevant medical or dental information. In that event such disclosure of personal details is minimised wherever possible.*
- 3. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may ask to look at, or get summaries of your treatment at any time, or seek an explanation of such records from the dentist. Fees may be charged to provide copies of certain records. You will be advised beforehand if fees are chargeable.*
- 4. If any of our records about you are inaccurate, you may ask us to alter them accordingly.*

Your health information is treated with the utmost confidentiality and will not be disclosed to any person not involved in either your treatment or the administration of this practice without your consent. If you have any queries or concerns about the handling of your health information please do not hesitate to raise these concerns with our practice.

If you are happy with the above please sign below to show that you consent to the use of your health information in this way.

Signed..... Date

MERCURY TOXICITY SCREENING

PLEASE CHECK ALL PAST OR PRESENT SYMPTOMS WHICH APPLY TO YOU.

1. HEART PROBLEMS

....heart attack
....heart or chest pains
....tachycardia [heart racing]
....abnormal E.K.G.
....heart murmur
....partial heart block
....endocarditis
....angina
....high blood pressure
....low blood pressure

2. SKIN PROBLEMS

....unexplained rashes
....excessive itching
....red flushes of colour
....rough skin
....acne [pimples]

3. NERVOUS DISORDERS

....Multiple Sclerosis
....Bell's Palsy
....Shingles [herpes zoster]
....numbness in any part of the body
....tingling in any part of the body
....epilepsy or convulsions
....Dr. told you "it's your nerves."
....shakes of the hands, feet, head etc.
....twitching of the face or other muscles

4. DIGESTION

....diverticulitis
....ulcers
....Crohn's disease
....Graves disease
....indigestion
....bloated feeling after eating
....heartburn
....poor appetite
....diarrhea

5. BLOOD DISEASE

....mononucleosis
....false positive for venereal disease

6. ALLERGIES

....metals [copper, nickel etc.]
....foods
....fabrics
....soaps and detergents
....other

7. ENDOCRINE PROBLEMS

....thyroid [underactive or overactive]
....pancreas
....diabetes
....ovaries
....testes
....menstruation [painful, irregular]
....hysterectomy
....tipped uterus
....cervical erosion
....prostate problem
....overweight
....underweight

8. EMOTIONAL

....sudden anger
....depression
....wishing you were dead
....irritability
....suicidal tendencies

9. ANNOYING SYMPTOMS

....frequent headaches
....noises in your ears
....ringing in your ears
....hissing in your ears
....chronic eye inflammation
....chronic fatigue
....tiring easily
....swollen lymph glands
....hearing problems
....perspire excessively
....cold hands and feet
....motion sickness
....slow healing
....leg cramps
....dizziness
....get up at night to urinate
....insomnia
....tired when wake up in the morning
....trouble making decisions

10. CANCER

....leukaemia
....Hodgkin's disease
....any other?

11. DISEASES

....arthritis [rheumatoid, osteoid]
....bursitis
....tennis elbow
....painful joints
....Friedrich's ataxia
....asthma
....surgery of any kind
....osteomyelitis
....psoriasis
....sickle cell anaemia
....chronic anaemia
....kidney stones

12. DENTAL HISTORY

....had silver amalgams
....have silver amalgams
....had gold fillings
....have gold fillings
....removeable metal partial denture
....gold bridge
....porcelain caps [crowns]
....non-precious crowns
....root canal fillings
....metallic taste in the mouth
....burning sensation in the mouth
....increased flow of saliva
....more than half your teeth removed
....periodontal disease [gum disease]

13. MISCELLANEOUS

....infections take a long time to heal
....do you work around mercury?
 [what capacity?]
....what medications are you taking?