

PATIENT HISTORY SHEET

In order for this dental practice to provide the highest standard of care, it is requested that you fill in this form carefully and thoroughly.

All information provided will be kept strictly confidential.

| Email: | Surname: | | | | | | |
|--|--------------------------------------|---------------|------------|--|-------------|-----------------|--|
| Address: | | | | | | | |
| Medical Doctor: | | | | | | P/Code: | |
| Who recommended you to our practice? Do you have dental insurance? | Emergency Contact: | Relationship: | Ph: | | | | |
| PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING: YES NO High blood pressure Diabetes Diabet | Medical Doctor: | | | Ph: | | | |
| PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING: YES NO High blood pressure | Who recommended you to ou | r practi | ce? | | | | |
| YES NO High blood pressure | Do you have dental insurance | e? □N | No | □ Yes Which health fund? | | | |
| High blood pressure | PLEASE INDICATE IF | YOU | HAVE | EVER HAD ANY OF THE FOLLO | WING: | | |
| Diabetes | | YES | NO | | YES | NO | |
| Heart Disease | High blood pressure | | | Anxiety/Depression/Mental Illness | | | |
| Thyroid problems | Diabetes | | | Physical disability | | | |
| Tuberculosis | Heart Disease | | | Asthma, chest or breathing probler | ns 🗆 | | |
| Kidney disease | Thyroid problems | | | Rheumatic fever | | | |
| Hepatitis | Tuberculosis | | | Epilepsy | | | |
| HIV/AIDS | Kidney disease | | | Excessive bleeding or blood disord | ler 🗆 | | |
| Medicinal allergies (e.g. Penicillin, Latex, etc)? Y / N Please specify invironmental allergies (Nuts, Grass, Pets, etc)? Y / N Please specify invironmental allergies (Nuts, Grass, Pets, etc)? Y / N Please specify faking any drugs, medicines or tablets? Y / N Please specify ist any past or present illnesses not covered above female patients, are you pregnant? Y / N Please specify Female patients, are you pregnant? Y / N Please specify Y / N Please specify Y / N Please specify Female patients, are you pregnant? Y / N Please specify Y / N Please specify Female patients, are you pregnant? Y / N Please specify Y / N Please specify Female patients, are you pregnant? Y / N Please specify Y / N Please specify Y / N Please specify Female patients, are you pregnant? Y / N Please specify Y / N Please specify Y / N Please specify Female patients, are you pregnant? Y / N Please specify Female patients, are you pregnant? Y / N Please specify Female patients, are you pregnant? Y / N Please specify | Hepatitis | | | Stomach/Bowel problems (e.g. ulce | er) 🗆 | | |
| Medicinal allergies (e.g. Penicillin, Latex, etc)? Y / N Please specify Environmental allergies (Nuts, Grass, Pets, etc)? Y / N Please specify Artificial hip, knee, heart valve or prosthetic implant? Y / N Please specify Faking any drugs, medicines or tablets? Y / N Please specify Environmental allergies (Nuts, Grass, Pets, etc)? Y / N Please specify Faking any drugs, medicines or tablets? Y / N Please specify Female patients, are you pregnant? Y / N Have you ever had problems with dental treatment? Y / N Fo you experience headaches/ migraines/ jaw problems frequently? Y / N The have completed the questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. Female patients, are you pregnant? Fo y / N Please specify Female patients, are you pregnant? Y / N Please specify Female patients specify Y / N Please specify Female patients specify Y / N Please specify Y / N N / N Please specify Y / N Please sp | HIV/AIDS | | | Bone Disease/Arthritis | | | |
| cinvironmental allergies (Nuts, Grass, Pets, etc)? | Do you smoke? | | | How many?/day | | | |
| Artificial hip, knee, heart valve or prosthetic implant? Y / N Please specify Faking any drugs, medicines or tablets? Y / N Please specify First any past or present illnesses not covered above Female patients, are you pregnant? Y / N Flave you ever had problems with dental treatment? Y / N Flave you experience headaches/ migraines/ jaw problems frequently? Y / N Flave completed the questionnaire to the best of my knowledge, and understand that failure to make a full disclosure have place me at undue medical risk. Flease Initial Flease Initial Understand that I will be charged a cancellation fee if I fail to attend or fail to give notice at least 24 hrs prior my ppointment. Flease Initial Flease Initial Flease Initial Flease Initial Flease Initial | ledicinal allergies (e.g. Penicillin | , Latex, | , etc)? | Y / N Please specify | / | | |
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| Name of Patient/ Parent /Legal guardian:Sign:Sign: | understand that my dental treatmer | nt is to b | e PAID I | N FULL on the day of treatment. | □ Plea | ase Initial | |
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| we would like to know which of the following is most important to you. (Please tick one) | |
|---|----|
| □ Comfort - Feeling comfortable/relaxed during and after your visit. | |
| □ Function - Being able to chew, speak and clean your teeth properly. | |
| □ Cosmetic - Being happy with your smile and how your teeth look. | |
| □ Longevity - Meaning long-lasting results and keeping your teeth and gums healthy. | |
| When considering future treatment, would any of these be a barrier or concern for you? (Please any that could apply) | |
| □ Time | |
| □ Fear | |
| □ Trust | |
| □ Budget | |
| Oral Hygiene Questionnaire | |
| Please circle how you feel about your smile on a scale of 1-10: 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - | 10 |
| 1. How often do you visit the dentist? | |
| □ Every 6mth | |
| □ Every year | |
| □ When in pain□ Not regularly | |
| | |
| 2. What prevented you from visiting the dentist regularly? | |
| | |
| | |
| 3. How often do you brush your teeth? | |
| 4. What do you use to clean your teeth? | |
| □ Tooth Brush | |
| □ Tooth Paste | |
| □ Floss | |
| □ Toothpick | |
| □ Mouth Rinse | |
| □ Tongue Cleaner | |
| 5. Do you experience any of the following? | |
| □ Bleeding gums | |
| □ Sensitive teeth | |
| □ Bad breath | |
| □ Dry mouth | |
| 6. Do you know gum disease has a direct link to your heart and general health? | |
| □ Yes | |
| □ No | |
| | |

At Smiles First, we have four values that drive our quality of care. All of them are really important to us, and

THANK YOU
AND
WELCOME TO SMILES FIRST.