**BRIGHT SMILE DENTAL SURGERY**

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# PATIENT HISTORY SHEET

WELCOME TO OUR PRACTICE!

Our records are confidential.

Please answer the following questions as accurately as possible

Title:…… Surname:…… Other Names:……
Date of Birth:…… Mobile Phone:……
Address :Home:……P/Code:……Phone:……
Business address:…… …… P/Code:……Phone:……
Person Responsible for fees: ……
Address: …… Phone:……
Emergency Contact: …… Phone:……
Who recommended this practice to you:……
Do you have dental insurance? YES / NO Which fund? ……

**Have you ever had any of the following? Please indicate**.

| | | | | | |
|---|---|---|---|---|---|
| Rheumatic Fever | YES / NO | Diabetes | YES / NO | Heart Ailment | YES / NO |
| Epilepsy | YES / NO | Kidney Disease | YES / NO | High Blood Pressure | YES / NO |
| Asthma | YES / NO | Excessive Bleeding | YES / NO | | |

Are you **ALLERGIC** to any drugs, medicines or latex? YES / NO Please list: ……
Do you have an artificial hip, heart valve or other prosthetic **implant**? YES / NO
If YES, please detail: ……
Have you ever been **hospitalized**? YES / NO Please detail: ……
Are you presently under any medical care or taking any medications? YES / NO
If YES, please detail: ……
Ladies, are you pregnant? YES / NO / MAYBE Do you smoke or use tobacco? YES / NO
Have you ever had any problems with Dental Treatment? YES / NO
If yes, please describe: ……

**Many precautions are routinely taken at this practice to protect all patients and those working here. People at high risk may require additional care because of increased susceptibility to infection and disease**.

**High Risk groups** are: Those who have contacted Hepatitis
Persons with antibodies to AIDS and Hepatitis
Homosexuals and bi-sexuals
Intravenous drug users
Recipients of blood or blood products
Sex industry workers
Sexual partners and children of the above

**Please circle**: I am not in a high risk group
I may be in a high risk group
I wish to discuss this in private with the dentist

**What is the purpose of your visit today?(PTO for more details)** ……

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place ME at undue medical risk.
(Note: Please give us 24 hrs notice if an appointment has to be cancelled. Otherwise, **a cancellation fee of up to $50 per half hour may apply**)

**SIGNED**:……**DATE**: …… **CHECKED(DR)**……

## WHAT IS THE PURPOSE OF YOUR VISIT?

Please circle the appropriate problem(s) that apply to you. More than one/None may apply to you

1. Toothache
2. Sensitive teeth(cold/Hot)
3. Bleeding gums
4. Loosening teeth
5. Missing teeth
6. Unsatisfactory denture
7. Rapid decaying teeth
8. Lost filling/Cavity
9. Grinding/Clenching teeth
10. Worn/Broken Teeth-Sharp points
11. Sounds (Clicking) from Jaw
12. Pain in face, muscles around the mouth and/or neck
13. Pain in jaw joints
14. difficulty/discomfort when chewing
15. Heavy snoring/sleep apnea
16. Discoloured teeth and/or Restorations)
17. Bad appearance
18. Other. Pls give details ……..

**Or** I don't experience any problems

**Signature** ……
**Checked(Dr)** …….