verve dental
your health. your vitality. our passion.

○ Dr ○ Mr ○ Mrs ○ Ms ○ Miss

Surname: First Name: D.O.B.

Address:

Suburb: Postcode:

Home Phone: Business Phone: Mobile:

Email Address:

Preferred Contact: ☐ Email ☐ SMS ☐ Phone Occupation:

Emergency Contact Name: Emergency Contact Number:

Dental Insurance Company Name (if applicable):

Who referred you to our practice?

How did you hear about Verve Dental:

☐ Website ☐ Google Search ☐ Drove past ☐ Local advertising ☐ Other

Are you or have you ever been treated for any of the following:

- ☐ Rheumatic fever
- ☐ Diabetes
- ☐ Hepatitis B
- ☐ Hepatitis A or C
- ☐ Nervous disorders
- ☐ Hyperglycaemia
- ☐ Multiple Myeloma
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Epilepsy
- ☐ Angina
- ☐ Osteoporosis
- ☐ Paget's Disease
- ☐ HIV
- ☐ Heart Ailments
- ☐ A Stroke
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood disorders
- ☐ Cancer
- ☐ Arthritis

Do you have any drug allergies? ○ Yes ○ No

If you answered yes, please list

Are you currently receiving any medical treatment? ○ Yes ○ No

Are you currently taking any medications? ○ Yes ○ No

If you answered yes, please list

☐ I have confidential medical information that I do not wish to write down. I would prefer to discuss this with the dentist directly.

CONTINUED OVER ▶

Have you ever had an unfavourable reaction to local anaesthetics? ◯ Yes ◯ No

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

Name of Medical Practitioner _____ Tel. No: _____

What is the purpose of your visit today? _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I routinely see my dentist every: ☐ 3 mth ☐ 4 mth ☐ 6 mth ☐ 12 mth ☐ Not routinely

Previous dental x-rays were taken: ☐ Less than a year ☐ Longer than a year

Are you happy with your smile? ◯ Yes ◯ No

If no, is there anything you would like to change about your smile _____

Do you have difficulty opening your mouth? ◯ Yes ◯ No

Do you hear noises from your jaw joint? ◯ Yes ◯ No

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

Do you have pain in or about the ears or cheeks? ◯ Yes ◯ No

Do you have pain when chewing, yawning or opening wide? ◯ Yes ◯ No

Does your bite feel unusual or uncomfortable? ◯ Yes ◯ No

Have you had an injury to your jaw, head or neck? ◯ Yes ◯ No

Have you previously been treated for temporomandibular disorder? ◯ Yes ◯ No

Have you ever had orthodontic treatment? ◯ Yes ◯ No

Do you smoke? ◯ Yes ◯ No

Do you think you have occasional bad breath? ◯ Yes ◯ No

How often do you brush your teeth?

☐ Once a day ☐ Twice a day ☐ Three times

Do your gums bleed when you clean your teeth? ◯ Yes ◯ No

Do you floss?

☐ Everyday ☐ Rarely ☐ Never

Does floss ever tear between your teeth? ◯ Yes ◯ No

Do you experience sensitivity with hot/cold? ◯ Yes ◯ No

Does food get jammed between your teeth? ◯ Yes ◯ No

We take your privacy seriously. We will not disclose any details unless you have authorised us to do so. You can view our Privacy Policy at vervedental.com.au.

This is a true and accurate medical history and I understand and accept Verve Dental's Privacy Policy.

Signature: Print and Sign Date: _____

Thank you for answering our questions.

Payment is required at the time of treatment. For your convenience we accept cash, cheques, EFTPOS credit cards