Welcome To Our Practice (02) 9953 0895

PROGRESSIVE DENTAL

Welcome to our practice. We look forward to giving you the best service possible so that you can enjoy the benefits of optimal dental health.

Patient Details

Title: **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Dr** ☐ **Other** ______________________________

Given Name: ______________________________ Surname: ______________________________

Date of Birth: ________/________/________

Residential Address: ____

Suburb: ______________________________ P/Code __________ State: ____________________

Contact: (Home) ______________________________ Mobile: ______________________________

Contact (Work) ______________________________ Email: ______________________________

Health Fund ____________________ Number ________________ Position __________

Occupation: ______________________________ Company: ______________________________

Dental History

What bothers you most about your teeth? ……………………………
Have you had any unpleasant dental experiences? (we will do WHATEVER it takes to make sure it is not repeated) ………………………
Reason for Attendance? ....
How long since you last saw a dentist? ....
How long since your last dental x-rays? ....
Have you had your wisdom teeth removed? .------------Yes / No / Some
Does food catch between your teeth? --------------------------------Yes/ No
Are you aware of clenching or grinding?--------------------------------Yes/ No
Does your jaw click or hurt ? --Yes/ No
Are you happy with the general appearance of your teeth? --------Yes/ No
Are you happy with the colour of your teeth? ------------------------Yes/ No
Do your gums bleed when you wash your teeth?--------------------Yes/ No
Do you get any sensitivity on biting cold, hard or sweet food?----Yes/ No
Do you suffer from bad breath?--Yes/ No
Have you ever been referred to Endodontist ----------------------Yes/ No Orthodontist Yes/ No Oral Surgeon Yes/ No Periodontist Yes/ No

Medical History *Please indicate below:*

- ☐ Abnormal Bleeding
- ☐ Angina
- ☐ Artificial Heart Valves/Valve Defect
- ☐ Asthma
- ☐ Blood Pressure High ☐ Low ☐
- ☐ Bisposphonates – Bone Disease
- ☐ Cardiac Surgery/Pacemaker
- ☐ Congenital Heart Defect
- ☐ Diabetes Type 1 ☐ Type 2 ☐
- ☐ Epilepsy
- ☐ Infectious Diseases: ________________
- ☐ Joint Replacement: ________________
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis A ☐ B ☐ C ☐ D ☐
- ☐ HIV Positive
- ☐ Nervous Disorders
- ☐ Oral Cancer
- ☐ Pregnant? Due Date: _______
- ☐ Rheumatic Heart Disease
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Warfarin Medication
- ☐ Other Serious Illness

Are you taking Medication? If yes, please list below:

______________________________ ______________________________ ______________________________

DENTAL ALLERGIES *Please Circle*

Penicillin **Y / N** Aspirin **Y / N** Iodine **Y / N** Sulpha Drugs **Y / N** Latex **Y / N**

Other: ____

How did you hear about us ? Please specify as much as possible

Referred by a Friend ..(who)... **Website (which)................................... Welcome Voucher .**

Other Business Recommendation .... **Street Signage ....** **Advertisement .(where)..........................**

1.I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand payment is due at the time of the service unless other arrangements have been made.

2.I hereby authorize doctor or designated staff to take x rays , study models, photograph, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Patient's Signature: ______________________________ **Date:** ____________________

Chronic recurring headaches…………………………………………… Yes / No
Clicking , popping or grating sounds in jaw joints ……… …………….. Yes / No
Limited jaw opening .... Yes / No
Jaw locking either open or closed .... Yes / No
Pain when chewing .... ……………………….. Yes / No
Earache and / or ringing in the ears …………………………………… Yes / No
Difficulty Swallowing. ……………………………………………………… Yes / No
Neck pain………………………………………………………………….. Yes / No
Throat pain... Yes / No
Pain behind the eyes ……………………………………………………….. Yes / No
Dizziness……………………………………………………………….... Yes / No
Pain in jaw muscles particularly in the cheeks and temporal areas……. Yes / No
Scalp Tenderness.. Yes / No
Teeth Grinding or clenching... Yes / No
Difficulty Biting…………………………………………………………………. Yes / No

Intermittent snoring with pauses………………………………………….. Yes / No
Awakening gasping or choking …………………………………………… Yes / No
Reflux……………………………………………………………………….. Yes / No
Fragmented Light Sleep…………………………………………………… Yes / No
Excessive Daytime Sleepiness …………………………………………… Yes / No
Poor Memory ……………………………………………………………….. Yes / No
Irritability …………………………………………………………………….. Yes / No
Morning Headaches ………………………………………………………… Yes / No
Clumsiness…………………………………………………………………. Yes / No
High Blood Pressure ……………………………………………………….. Yes / No
Bed wetting (children) ……………………………………………………. Yes / No
Bruxism ……………………………………………………………………….. Yes / No
Weight Gain ………………………………………………………………….. Yes / No
Elevated Pain levels particularly in patients with chronic pain ………… Yes / No

Daytime Sleepiness Evaluation
Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr John Murray of Melbourne Australia. It is a simple, self – administered questionnaire – widely used by sleep professionals in quantifying the level of daytime sleep.
For the following situations, answer with one of the following numbers:

0. **Would never dose**
1. **Slight chance of dozing**
2. **Moderate chance of dozing**
3. **High chance of dozing**

Situation	Score
Sitting and Reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying Down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	