

**CONFIDENTIAL EVP DENTAL MEDICAL HISTORY  
NEW PATIENT PRE-TREATMENT DETAILS**

Welcome to EVP Dental, please answer all of the following questions as accurately as possible to assist us in our effort to provide you with the best dental treatment.

***All information will be treated with complete professional confidentiality.***

Dr.    Mr.    Mrs.    Ms.    Miss.    Mstr.

Surname \_\_\_\_\_ First Name \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Email: \_\_\_\_\_

Occupation \_\_\_\_\_

Who is responsible for payment of your account? \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Preferred payment method:    Cash:                    Chq:                    Eftpos:                    Cr Card:

Do you have private health cover?    Yes    No    which fund? \_\_\_\_\_

Do you have an immediate dental problem? \_\_\_\_\_

How long has it been since your last dental examination? \_\_\_\_\_

Were x-rays taken at your last visit? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you use dental floss? \_\_\_\_\_

Do your gums bleed or feel tender? \_\_\_\_\_

Are your teeth sensitive to hot, cold or sweet foods? \_\_\_\_\_

Are you aware that you clench or grind your teeth? \_\_\_\_\_

Are you conscious of the colour of your teeth?    Yes    No

Are you conscious of the appearance of your teeth?    Yes    No

Are you particularly nervous about dental treatment? \_\_\_\_\_

Do you normally have injections for dental treatment? \_\_\_\_\_

**PLEASE TURN OVER**

