Canberra Implant & Periodontal Centre

Suite 203 Northpoint Plaza, 8 Chandler Street, Belconnen ACT 2617

PERSONAL DETAILS

Title (circle one) Mr / Mrs / Ms / Miss / Dr /Prof / Other_____

Family name_____ First name_____

Preferred name _____

Date of birth_____

Home address_____

_____ Post code _____

Postal address _____

_____ Post code _____

Home phone _____ Business phone _____

Mobile phone _____ Fax number _____

Email address _____

Occupation _____

Who is your normal dentist?_____

Who referred you to this practice? (Circle one) Same as above / other_____

Are you covered for dental treatment?_____

If so, to which fund do you belong?_____

Details of person to contact in an emergency

Name_____ Phone _____

Medical doctors name _____Phone _____

Specialist Doctors Name *(if applicable)* _____Phone _____

MEDICAL HISTORY

In order to provide treatment of a high standard it is necessary to have details of your medical and dental history. We ask that you provide the following information, which will be treated in the strictest confidence.

Are you currently receiving any medical treatment? Yes / No

If yes please give details _____

Are you currently taking any medication or drugs? Yes / No

If yes please give details _____

Have you had any allergies / reactions / unusual effects from medication (eg penicillin), anaesthetics or antiseptics? Yes / No

If yes please give details_____

PLEASE CONTINUE OVER THE PAGE

MEDICAL HISTORY (continued)

Have you ever had or do you now have any of the following

Rheumatic fever	Yes	No	Nervous disorders	Yes	No
Heart problems	Yes	No	Depressive illness	Yes	No
Angina	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Epilepsy	Yes	No
Respiratory problems	Yes	No	Severe headaches	Yes	No
Sinus	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Thyroid disorder	Yes	No
Blood disorder	Yes	No	Kidney or Liver disorder	Yes	No
High blood pressure	Yes	No	Gastric problems	Yes	No
Hepatitis/Infectious disease	Yes	No	Any other serious illness	Yes	No

If you have answered YES to any of the above please give details

_____

Have you had or do you now have any of the following

Osteoporosis	Yes	No	Multiple myeloma	Yes	No
Cancer which has spread to the bones	Yes	No	Any other bone condition	Yes	No
Paget's disease	Yes	No			

If you have answered YES to any of the above please give details

_____

Are you taking any bisphosphonate medications? Yes / No

Do you have a latex allergy? Yes / No

What is your HIV status? Positive / Negative / Never tested

Have you had a blood transfusion since 1980? Yes / No

Do you have a pacemaker or any replacement joints or transplants? Yes / No

If yes please give details_____

Do you have now, or have you ever had gout? Yes / No

Are there any other details of your medical history which you feel we should be aware of?

_____

Female patients only

Are you pregnant? Yes / No If so, how many weeks_____

Are you taking any birth control medication? Yes / No
(*NB: Certain antibiotics can neutralise the effects of birth control medication*)

DENTAL HISTORY

Have you ever experienced excessive bleeding or bruising? Yes / No

If yes please give details _____

Do your gums bleed when you brush your teeth? Yes / No

Do you use dental floss? Yes / No

Do you use interdental brushes? Yes / No

Have you had or do you now have any of the following

Periodontal or gum treatment	Yes	No	Dental implants	Yes	No
Dental infections	Yes	No	Oral surgery	Yes	No
Bleeding post treatment	Yes	No	Orthodontic treatment	Yes	No

Do you smoke? Yes / No If yes - how many per day _____

How do you feel about dental treatment? (Circle one)

(Comfortable) 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (Very distressed)

What is your biggest concern about dental treatment? _____

PRACTICE POLICIES

- You acknowledge that you will pay for your treatment in full at each appointment. We accept cash, cheques, eftpos and credit cards (Amex, Mastercard and Visa)
- You acknowledge that as a courtesy you will give us at least 2 business days notice if you need to reschedule an appointment
- From time to time we participate in hands-on educational programmes, which sometimes require treatment records of patients. All such records (including photographs and x-rays) are used anonymously. If the need arises would you allow your treatment records to be utilised for this purpose? Yes / No

Signed: Patient/Parent/Guardian _____ Date: _____

ACCOUNT DETAILS

If patient is a minor – please supply parent name for account purposes

_____

Is there an insurance / third party / workers compensation claim associated with this treatment? Yes / No

If yes – please supply details of claim

Type (circle one) insurance / third party / workers compensation claim

Company_____

Address_____

Phone_____ Claim No_____