Canberra Implant & Periodontal Centre

PERSONAL DETAILS

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

Surname: _____ First name: _____

Preferred name: _____

Date of birth: _____ Occupation: _____

Address: _____ Postcode:_____

Mobile phone: _____ Home phone: _____ Work phone: _____

Email address: _____

Children under the age of 18 years, name of parent/guardian: _____

Who is your normal dentist? _____

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

Private health insurer: _____ Member No: _____ Patient No: _____

Details of person to contact in an emergency:

Name: _____ Phone: _____ Relation: _____

MEDICAL & DENTAL 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 please provide the following information.

- Have you had any ALLERGIES / REACTIONS / UNUSUAL EFFECTS from medication (eg penicillin), anaesthetics or antiseptics? **Yes /No**

If yes please give details: _____

- Do you have a latex ALLERGY? **Yes / No**
- Are you taking any blood thinning medication? **Yes / No**

If yes please give details: _____

- 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: _____

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

If yes please give details/date placed:_____

- Do you have osteoporosis? **Yes / No**

If yes and take medication please give details:_____

MEDICAL & DENTAL HISTORY (continued)

Have you ever had or do you now have any of the following? (circle yes or no)

Angina	Yes	No	Heart Problems	Yes	No
Arthritis	Yes	No	High Blood Pressure	Yes	No
Asthma/Respiratory issues	Yes	No	Kidney or Liver Disorder	Yes	No
Blood disorder/transfusion	Yes	No	Migraine	Yes	No
Cancer	Yes	No	Nervous Disorders	Yes	No
Depressive Illness	Yes	No	Pagets Disease	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Epilepsy	Yes	No	Sinus issues	Yes	No
Excessive bleeding / bruising	Yes	No	Stroke	Yes	No
Gastric problems	Yes	No	Thyroid Disorder	Yes	No
Gout	Yes	No	Any other serious illness	Yes	No
Hepatitis A/B/C or Infectious Disease (HIV)	Yes	No	Cancer which has spread to the bones	Yes	No

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

_____

_____

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

_____

- Do you smoke or vape? **Yes / No** **If yes** - how many per day: ____
- **Female Patients Only:** Are you pregnant? **Yes / No** If so, how many weeks: ____

How do you feel about dental treatment? Circle one: (Relaxed) 1-2-3-4-5-6-7-8-9-10 (Very distressed)

What is your biggest concern about dental treatment? _____

PRACTICE POLICIES

- By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this new patient/medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the dentists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependants; (iv) payment in full is due at the time of service. We accept cash, cheques, eftpos and credit cards (Amex, Mastercard and Visa)

- The specialists at CIPC are both national & international speakers. We request permission to use any clinical radiographs and/or photographs taken of your procedure. Your privacy and anonymity is assured.

  Yes/No

- All personal information collected by Canberra Implant & Periodontal Centre is handled in accordance with our privacy policy. For more information, please request to see our privacy policy or read The Australian Charter of Healthcare Rights.

Signed: Patient/Parent/Guardian _____ Date: _____