Canberra Implant & Periodontal Centre

1st Floor, Altitude 350, 77 Emu Bank, Belconnen, ACT 2617

PERSONAL DETAILS

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

Surname: ________________________________ First name: ________________________________

Preferred name: ____

Date of birth: ____

Home address: ____

____ Postcode: __________________________

Postal address (if different): ____

____ Postcode: ______________________

Mobile phone: _______________ Home phone: _______________ Work phone: _______________

Email address: ____

☐ We will send you marketing email communications from time to time. Please tick this box if you **do not** wish to receive communication from us

Occupation: ____

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: __________________

General Practitioner 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: ____

MEDICAL HISTORY (continued)

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

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

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

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

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Are you taking any medication for osteoporosis? **Yes / No**

If yes please give details: ____________________

Are you taking any blood thinning medication? **Yes / No**

If yes please give details: ____________________

Do you have or do you suspect that you may have a bloodborne virus eg: Hep B, Hep C or HIV?

Yes/No/Unknown

Do you have a latex allergy? Yes / No

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?

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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? ____

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*)

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)

- 2 business days notice is preferred if you need to reschedule an appointment.

- 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: ____________

ACCOUNT DETAILS

Are you responsible for payment of the account? Yes / No

If not who is responsible for payment? (Tick one)

☐ Veteran Affairs: DVA Number: _______________________

☐ Dept of Defence: PM Keys: _______________________

☐ Compensation: Claim Number: _______________________

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