Moonee Ponds Periodontics & Implant Centre

PATIENT INFORMATION SHEET

Welcome to our practice! To assist in determining your treatment, please answer the following questions as accurately as possible. All information will be held in confidence according to our privacy policy.

Dr/ Mr/ Miss/ Mrs/ Ms Surname _____ First Name _____

Age _____ Date of Birth _____ Home Phone _____ (Area Code) Mobile _____ (Area Code)

Address _____ _____

_____ Postcode _____

Occupation __ _____ Business Phone _____

E-Mail _____ Your family dentist _____

How long have you been his/her patient? _____ Date of last visit _____

Who referred you to this office? _____

Do you have dental insurance? YES NO Fund_____ Membership # _____

HEALTH HISTORY

Your general health constitutes an important factor, and in combination with other causes, may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

Please **tick** the appropriate box in answer to the following questions.

Yes	No	?	
☐	☐	☐	Are you in good health? If no, what is the nature of your illness? _____
☐	☐	☐	Is a physician now treating you? If so, for what? _____
☐	☐	☐	Are you taking any drugs or medications? If so, what?
☐	☐	☐	Have you ever had excessive bleeding requiring special treatment? If so, details? _____
☐	☐	☐	Do you have diabetes?
☐	☐	☐	Has anyone in your family ever had diabetes? If so, who? _____
☐	☐	☐	Do you smoke? _____ If so, how much per day and for how long? _____
☐	☐	☐	Have you ever smoked? How long since you quit? _____
☐	☐	☐	Are you a blood donor?
☐	☐	☐	(For females) Are you pregnant? If so, due date _____

Have you had any of the following?

- ☐ Heart disease or arrhythmia
- ☐ Heart attack or coronary bi-pass surgery
- ☐ Rheumatic fever
- ☐ Tuberculosis or other lung disease
- ☐ Hepatitis, liver disease, yellow jaundice
- ☐ Tumour or cancer

Please Turn Over

- ☐ Pacemaker
- ☐ Stroke
- ☐ Hypertension (High blood pressure)
- ☐ Kidney disease
- ☐ Asthma
- ☐ Osteoporosis/Osteopenia
- ☐ Other serious illnesses _____

- ☐ Radiation or chemotherapy
- ☐ HIV / AIDS
- ☐ Blood problems, anaemia, leukaemia
- ☐ Creutzfeldt Jakob Disease
- ☐ Epilepsy
- ☐ Arthritis, joint problems or artificial joints

Have you ever shown an allergy to?

- ☐ Antibiotics. If so, which? _____
- ☐ Codeine
- ☐ Dental anaesthetic
- ☐ Latex
- ☐ Other. Please specify _____

- ☐ Penicillin
- ☐ Aspirin
- ☐ Morphine, Pethidine
- ☐ Any Metals

Have you ever been treated by a periodontist? Yes/No

If so when? _____

Please answer the following questions.

How often do you brush your teeth? **Never** **Occasionally** **Daily** **Twice Daily** **More often**

What type of toothbrush do you use? **Hard** **Medium** **Soft** **Electric**

How often do you use dental floss? **Never** **Occasionally** **Daily** **More often**

When were your teeth last “cleaned” by a dentist or dental hygienist? _____

How frequently have your teeth been “cleaned” by a dentist or dental hygienist in the last 5 years?

_____

Patient Statement Please Read Carefully Before Signing

To the best of my knowledge, the above information I have noted is correct.

I give permission for my dental records to be accessed by Dr Robert De Poi/Dr Nupur Kataria/Dr Melinda Newnham or their representatives in this practice. I further give permission for my records to be used for the purposes of audit and research with the understanding that I would not be personally identified in any way. I agree to personally be liable for payment of all fees not covered by or in the event any claim I may have against any Health Fund, WorkCover or other Third Party may be rejected. I understand that I will be responsible for all charges including consultation, treatment and diagnostic services and also understand that I shall be responsible for payment if outstanding accounts are sent to the debit collection agency.

_____

Patient’s Signature **Date**

You will be asked to review and sign this form in office at the time of your appointment!

Print Form **Submit Form**