park st perio
periodontics - dental implants

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In order to render dental treatment of a high standard, it is necessary to have the following information, which will be handled confidentially. Please fill this form in completely.

Mr / Mrs / Miss / Ms / Dr / Prof (Please circle one)

Name: (In full) _____Date of Birth: ____/____/_____

Street Address: _____

Suburb: _____ State: _____ Postcode: _____

Postal Address: (If different from above) _____

Home Phone: _____Mobile Phone: _____Business Phone: _____

Email address: _____

How would you like your appointment confirmed? Please circle one. SMS / Phone (home, work or mobile) / E-mail

Emergency Contact: (Name) _____Relationship: _____Phone: _____

Who referred you to this practice: _____

Medical Practitioner Name: _____ Address:_____Phone:_____

MEDICAL AND DENTAL HISTORY	YES	NO
Have you ever had heart trouble or high blood pressure?		
Have you ever had rheumatic fever, diabetes, hyperthyroidism, asthma, glaucoma, nervous disorders, anaemia?		
Have you ever had any other serious illness? If yes, please note the illness.		
Have you been a patient in hospital during the last two years?		
Are you under any current medical treatment?		
Are you currently taking any drugs or medicines? Please list medications. Are you on long-term aspirin? Have you ever taken any medication for bone density?		
Have you ever had any intravenous medications?		
Have you any known allergies to drugs (especially penicillin) medications or antiseptics?		
Have you ever experienced prolonged bleeding?		
Women, if pregnant, state how many months.		
Do you have or are you at risk of developing Hepatitis, HIV or any other infectious disease?		
Smoking status (Please circle) Current Former Never		

Signature: _____ Date: ____/____/_____