Melbourne Periocare

Periodontics & Implant Dentistry

7 Whitehorse Road, Balwyn 3103

Phone 03 98171860

PLEASE COMPLETE BOTH SIDES AND BRING TO APPOINTMENT

Patient Information

Mr/Mrs/Ms/Miss/Mst

Surname……

Given Name……..Preferred Name……

Address……

…… Postcode……

Phone Number (Home)…… (Work) ……Mum/Dad

Mobile:(Patient):……..(Mum/Dad):……

Emergency Contact ……

Email Address……

DOB:…… Occupation……

Dentist……Suburb……

Health Fund……

How did you hear about Our Practice?……**Please circle below**

Newspaper / Dentist / WebSite / Friend / Family / Yellow Pages / Other

What concerns you most about your gums or teeth?……

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

If so, how long ago……

How often do you brush your teeth? Please circle your answer

Never / Occasionally / Daily / Twice daily / More often

What kind of tooth brush do you use? Please circle your answer

Manual / Electric Soft / Medium / Hard

How often do you use floss or interdental cleaning aids? Please circle your answer

Never / Once / Twice daily / Occasionally / More than twice daily

When was the last time you had a **"teeth cleaning" done by a dentist** / hygienist?

……

Frequency of tooth cleaning visits in last 5 years.

……

Please turn over……

Medical Information:

Have you ever had any of the following? Please indicate:

	YES	NO		YES	NO
Diabetes	☐	☐	Rheumatic Fever/Arthritis	☐	☐
High/Low Blood Pressure	☐	☐	Asthma/Breathing Problems	☐	☐
Heart Ailment	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Thyroid Problems	☐	☐
Stomach/Bowel Problems	☐	☐	Hepatitis A, B, C	☐	☐
Kidney Disease	☐	☐	HIV/AIDS	☐	☐
Excessive Bleeding or Bleeding Disorders	☐	☐	Tumour/cancer	☐	☐
	☐	☐	Osteoporosis/Osteopenia	☐	☐
Other Conditions, if any	☐	☐	.....		

Do you Smoke or have you ever been a smoker? ☐ ☐

If yes, how much per day and for how long?.....

If you are an ex-smoker, how long since you quit? .....

Do you have an artificial hip, heart valve or other prosthetic implant? ☐ ☐

Are you presently under medical care?

Please explain.....

Are you presently taking any medication? ☐ ☐

Please list:.....

.....

Do you have any known allergies? ☐ ☐

Please list:.....

List any other previous illnesses/hospitalisations.....

.....

Have you ever had problems with dental treatment?.....

Female patients, are you pregnant? ☐ ☐

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS THOROUGHLY AS POSSIBLE

 # I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue risk. I understand that notes, radiographs (xrays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check up reminders

 # I give my consent for xrays, models and photographs to be used for research and continuing education purposes.....YES/NO

 # I am happy for Melbourne Periocare to contact me via email with regard to practice news and other initiatives .....YES/NO

Patient Signature :..... Date.....

ON FUTURE VISITS CHANGES TO THE ABOVE INFORMATION SHOULD BE ADVISED.