affinity periodontics
& implant dentistry

Welcome to Affinity Periodontics and Implant Dentistry!

Your "Confidential Patient Medical History" form is enclosed to complete at your convenience and to bring to your first visit with us. Also, please bring any referral letters, OPG's, x-rays and records given to you by your referring dentist.

The cost of the initial consultation will be **$255 plus the cost of any radiographs***. This fee is **payable on the day of consultation**. We accept VISA, EFTPOS, Mastercard, American Express or Cash. We also have HICAPS facilities if you have private dental insurance.

Our rooms are located within:

Ascot Vale Dental

97 Union Road

ASCOT VALE

Nearest tram stop: #35 Munroe St/ Bloomfield Rd on Union Road.

Our phone number is **9372 8007**. We request that you arrive 15 minutes early for your appointment with Adj. A/Prof Melinda Newnham.

Please note 24 hours' notice is required for any appointment cancellations or a cancellation fee will apply.

We look forward to meeting you.

*Fees are subject to change without notice.

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Confidential Patient Medical History

Welcome to Affinity Periodontics and Implant Dentistry! All information collected remains within the practice and will be held in confidence according to our privacy policy.

Title _____ Surname _____ First Name _____

Preferred Name _____ Date of Birth _____

Address _____Suburb_____

Home Phone _____ Mobile _____

Occupation _____ General Dentist _____

Who referred you to this office (if different from general dentist)? _____

Are you happy to receive correspondence by email? ☐ Yes / ☐ No

E-Mail _____

Do you have private health insurance with dental cover? ☐ Yes / ☐ No

If yes: Fund_____ Membership # _____

Medicare # _____ Patient # _____ Valid to _____

Medical Information

Please answer the following questions as accurately as possible so that we may include this information in your diagnosis and treatment plan. If you are unsure, please check the condition to discuss further with your practitioner.

Please check the relevant boxes applicable to you (eg. ■ Arthritis / Artificial Joint).

- ☐ High Blood Pressure / Heart disease / Arrhythmia
- ☐ Excessive Bleeding / Bleeding Disorders
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Heart disease
- ☐ Pace Maker
- ☐ Heart Attack
- ☐ Bypass Surgery / Heart Valve Surgery
- ☐ Organ transplants / immune suppression
- ☐ Diabetes: Type 1 / Type 2
- ☐ Kidney Disease
- ☐ Arthritis / Artificial Joint
- ☐ Osteoporosis / Osteopenia – *please list all medications below – eg. Fosamax, Prolia, Evenity)*
- ☐ Liver Disease / Hepatitis A, B, C
- ☐ Stroke
- ☐ Epilepsy
- ☐ HIV

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Do you have any history of tumours or cancer? ☐ Yes / ☐ No What type?_____

Do you smoke or vape? ☐ Yes / ☐ No How many cigarettes or vapes do you have per day? _____

Are you pregnant? ☐ Yes / ☐ No How many weeks? _____

Are you a blood donor? ☐ Yes / ☐ No

Additional information/ comments:_____

MEDICATIONS

It is important to list all medications you are taking. This includes all **oral medications** and **regular injections**. Please list all medications including injections.

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES & ADVERSE REACTIONS

Please list all known allergies and previous adverse reactions to any medications, including antibiotics, local anaesthetic and latex.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Consent to Treatment

1. I hereby authorize the periodontist or trained staff to take x-rays, photographs or other diagnostic aids deemed appropriate by the periodontist to make a thorough diagnosis. Photographs may be used for teaching purposes.

2. I agree that the above is a true and accurate record. I understand that Affinity Periodontics & Implant Dentistry requires payment on the day of treatment. Any expenses, costs or disbursements incurred by Affinity Periodontics & Implant Dentistry in recovering outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also require a deposit prior to scheduling any future appointments.

Please Note: The medical history form will be electronically copied to your file and the original will be subsequently destroyed. By signing this document, you agree to this process. This form is a guide only and you should discuss any relevant matters with your periodontist prior to the commencement of any dental treatments.

Signature: _____ Date _____