



## Confidential Patient Medical History

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? \_\_\_\_\_

Are you happy to receive correspondence by email? **Yes** **No**

Email: \_\_\_\_\_

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 any boxes applicable to you:

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Diabetes Type 1 / 2 / Gestational    |
| <input type="checkbox"/> Heart disease                   | <input type="checkbox"/> Kidney Disease                       |
| <input type="checkbox"/> Heart attack / Arrhythmia       | <input type="checkbox"/> Rheumatoid Arthritis/ Osteoarthritis |
| <input type="checkbox"/> Bleeding Disorders              | <input type="checkbox"/> Artificial Joint _____               |
| <input type="checkbox"/> Rheumatic Fever                 | <input type="checkbox"/> Osteoporosis / Osteopenia            |
| <input type="checkbox"/> Heart murmur                    | <input type="checkbox"/> Liver Disease / Hepatitis A, B, C    |
| <input type="checkbox"/> Pacemaker / defibrillator       | <input type="checkbox"/> Stroke                               |
| <input type="checkbox"/> Bypass                          | <input type="checkbox"/> Epilepsy / nervous system disorders  |
| <input type="checkbox"/> Heart Valve replacement surgery | <input type="checkbox"/> HIV / AIDS                           |
| <input type="checkbox"/> Thyroid conditions              | <input type="checkbox"/> Chemotherapy / Radiotherapy          |
| <input type="checkbox"/> Inflammatory bowel conditions   | <input type="checkbox"/> Lung conditions incl. tuberculosis   |
| <input type="checkbox"/> Autoimmune conditions           | <input type="checkbox"/> Asthma                               |
| <input type="checkbox"/> Organ transplant                | <input type="checkbox"/> Emphysema/ COPD/ COAD                |
| <input type="checkbox"/> SLE (Lupus)                     | <input type="checkbox"/> Stomach disease                      |
|  | <input type="checkbox"/> Steroid therapy                      |



Do you have any history of tumours or cancer? **Yes No**

What type of cancer? \_\_\_\_\_

Do you smoke? **Yes No** How many cigarettes per day? \_\_\_\_\_

Do you vape? **Yes No** How many vapes per day? \_\_\_\_\_

Are you pregnant? **Yes No** Due date: \_\_\_\_\_

Are you a blood donor? **Yes No**

Under you under the care of a physician? **Yes No**

If yes, please list all conditions (including mental health): \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalised or had surgery? **Yes No**

If yes, please list the year and type of surgery: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional medical conditions not listed above: \_\_\_\_\_

\_\_\_\_\_

### 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, such as those for osteoporosis (e.g. Aclasta, Zometa, Prolia, Evenity).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Allergies and Adverse Reactions

Please list all known allergies and previous adverse reactions to any medications, including **antibiotics, local anaesthetics, chlorhexidine, codeine 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.
3. 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 \_\_\_\_\_