affinity periodontics
& implant dentistry

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? _____

Email: _____

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

Fund _____ Membership # _____

Medicare # _____ Patient # _____Valid to _____

Medical Information

Please indicate if you have any of the following conditions:

- High Blood Pressure
- Heart disease
- Heart attack
- Arrhythmia
- Pacemaker/ defibrillator
- Bypass surgery
- Heart valve replacement
- Rheumatic Fever
- Bleeding Disorders
- HIV / AIDS
- Thyroid conditions
- Asthma
- Emphysema/ COPD/ COAD
- Other lung conditions
- Stroke / TIA
- Epilepsy
- Anxiety/ depression
- Skin conditions
- Stomach conditions
- Inflammatory bowel conditions
- Liver Disease
- Hepatitis A, B or C
- Diabetes – type I / 2 / gestational
- Kidney disease
- Osteoporosis/ osteopenia
- Osteoarthritis / Rheumatoid Arthritis
- Joint replacements / artificial joint
- Immunologic injections
- Steroids
- Lupus
- Autoimmune conditions
- Organ transplant

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

What type of cancer? _____

Have you had chemotherapy? **Yes** **No** Have you had radiotherapy? **Yes** **No**

Do you smoke? **Yes** **No** Do you vape? **Yes** **No** Number per day? _____

Are you pregnant? **Yes** **No** Due date: _____

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

If yes, please list conditions treated: _____

_____

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:

Please list all medications you are taking including **oral medications and regular injections** (e.g. osteoporosis medications Fosamax, Alendronate, Aclasta, Zometa, Prolia, Evenity).

_____

_____

Allergies & 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 authorise 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.
3. 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.
4. 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 clinician prior to the commencement of any treatment.

Signature: _____ Date _____