Pacific periodontics & implants®

DR ADRIAN HOFFMAN
BDS(Syd), FDSRCS (Eng), MDSC (Qld), FRACDS (Perio)

DR MAZIAR TAVAZOEI
DMD, D.Clin.Dent (Perio)

MEDICAL AND DENTAL HISTORY FORM

WE RESPECT YOUR PRIVACY

It is important for us to know details of your medical and dental history so that your treatment plan can be tailored to your personal needs. We assure you this information will be held in strict confidence and not disclosed to any other persons or parties, unless you give permission to do so.

PERSONAL DETAILS

TITLE: MR / MRS / MS / MISS / MASTER / DOCTOR / CAPTAIN / OTHER _____

NAME: _____ D.O.B: ___ /___ /____

ADDRESS: _____

_____ STATE: _____ POSTCODE: _____

MOBILE: _____ HOME: _____ WORK: _____

EMAIL: _____ OCCUPATION: _____

PREFERRED CONTACT METHOD: SMS ☐ Mobile ☐ Telephone Work ☐ Telephone Home ☐ Email ☐

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

NAME OF HEALTH FUND: _____

MEDICAL DOCTOR'S NAME: _____ SUBURB: _____

REFERRING DENTIST'S NAME: _____ SUBURB: _____

HOW DID YOU HEAR ABOUT US: Website ☐ Yellow Pages ☐ Advertisement ☐ Patient Referral ☐

PATIENT REFERRAL - WHO? _____

07 5559 5911
pacificperio.com.au

Suite 1, 419 Golden Four Drive, Tugun QLD 4224 Australia
Shop 22 "The Boulevard", 70 River St.Ballina NSW 2478 Australia

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CANCELLATION POLICY

Dr Hoffman and staff do expect and appreciate you keeping your agreed appointment. If cancelling your appointment becomes unavoidable, the more notice you provide the better, as this enables us to reschedule other patients and avoid highly trained staff and equipment sitting idle. Consequently, we require one week notice, or 48 hours as an absolute minimum. If we receive less than 48 hours notice, a cancellation fee of $150.00 will apply.

- ☐ (Please tick to indicate that you have read and will comply with the above)
- ☐ I understand that all treatment is to be paid for on the day of treatment and all information collected will be treated in confidence (Please tick).
- ☐ I understand that I need to continue to see my general dentist for regular dental check-ups.

PATIENT/GUARDIAN SIGNATURE: _____ D.O.B: ___ /___ /_____

MEDICAL HISTORY:

Please indicate below if you have, or have ever, had any of the following:

Blood Disorder (anaemia/leukaemia) ☐	Prosthetic Heart Valve ☐	Bone Disease eg:- Osteoporosis ☐
Other blood disorder ☐	Heart/Cardiac pacemaker ☐	Paget's disease/cancer spread to bone/multiple myeloma ☐
Blood Pressure-High/Low ☐	Stroke ☐	Nerve/Muscular Disorder ☐
Cortico-Steroid therapy ☐	Radiation therapy ☐	Stomach disorder (gastritis) ☐
Diabetes Type I/Type II ☐	Lung disease (asthma/emphysema) ☐	Bowel disorder ☐
Epilepsy ☐	Tuberculosis ☐	HIV ☐
Heart murmur ☐	Kidney/Liver disease ☐	Hepatitis A, B or C (please circle) ☐
Heart surgery/disease/attack ☐	Thyroid disease ☐	Anxiety/Stress/Depression ☐
Females: Number of Pregnancies ☐	Prosthetic Joint (Hip/Knee) ☐	

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Have you ever taken Biphosphonate medication, e.g. Alendronate, Fosamax, Risedronate, Pamidronate, Zoledronic acid? Yes / No

Please briefly explain any medical treatment for any of the above conditions: _____

_____

Are you presently taking any medications? Yes / No

Please List: _____

_____

Are you presently taking any medications? Yes / No

If so, give details: _____

_____

Have you ever been a smoker? Yes / No

Do you currently smoke? Yes / No

If "No", when did you quit? _____

If "Yes" for how long? _____

How many per day on average? _____

PATIENT/GUARDIAN

NAME: _____ SIGNATURE: _____ D.O.B: ___ /___ /_____

DENTAL HISTORY:

FOR YOUR COMFORT: Many people are still nervous about coming to the dentist. Whilst the improvements in techniques and anaesthetics have helped most people, you may still be apprehensive and wish us to take extra measures for your comfort. Please circle the number that indicates your present level of apprehension.

Completely at Ease	0	1	2	3	4	5	6	7	8	9	10	**Petrified!**

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Have you had adverse reactions to local or general anaesthesia? Yes / No

Do you normally require antibiotic cover before treatment? Yes / No

Have you experienced any difficult extractions or bleeding problems as a result of dental treatment? Yes / No

ORAL HYGIENE:

When was your last dental cleaning? _____

Do you use an electric or manual tooth brush? _____

Do you use: Floss / tooth picks / interproximal brush _____

If "Yes" for how often? _____

PRESENTING COMPLAINT:

Are you aware of any of the following oral symptoms?

Nothing, dentist just referred me on	☐	Bad breath	☐
Bleeding on brushing	☐	Bad taste	☐
Bleeding on flossing	☐	Sensitivity to cold	☐
Loose/mobile teeth	☐	Staining	☐
Gum recession	☐	Abscess / gum boil	☐

Details: _____

_____

NAME: _____

PATIENT/GUARDIAN SIGNATURE: _____ D.O.B: ___ /___ /_____

CLINICIAN SIGNATURE: _____ D.O.B: ___ /___ /_____

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