Pacific periodontics & implants®

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

DR CHARLIE BOAST
BDS(Adel), D.Clin.Dent (Qld), FRACDS

DR SARAH BENTON
BDSc (hons)UWA, DClinDent(qld), FRACS

REGISTERED DENTAL SPECIALISTS

Dear, _____

We welcome you to our visiting practice in Cherry Street Ballina (please see map attached)

We look forward to seeing you for your first appointment with Dr Adrian Hoffman on:

Date: _____ Time: _____

Dr Hoffman graduated in dentistry in 1994 from the University of Sydney where he was elected President of the Dental Undergraduate Association. He then served in the Australian Army as a Captain Dental Officer for 2 years before relocating to the UK. Whilst training in Oral Surgery, Oral Medicine and Prosthodontics, he attained his Fellowship of the Royal College of Surgeons of England. Dr Hoffman returned to Australia in late 2000 to commence his 3 year specialist training program in Periodontics at the University of Queensland. Dr Hoffman was the President of the Australian Society of Periodontology (QLD) in 2006, and was the President of Gold Coast Dental Study Club in 2008.

In order to assist us we would appreciate it if you would bring with you the following items:

- Completed medical / dental history forms (please find enclosed).
- Referral letter and previous x rays (if not already sent by your dentist).
- Your existing manual or electric toothbrush.

At your initial appointment we will not carry out any active treatment, except (where necessary) for the relief of pain. A detailed examination will be completed and explanation of your individual findings. We will formulate a treatment plan to manage your dental requirements. This will help us determine the number and length of appointments required as well as the professional fees involved and their associated dental insurance item numbers. This consultation will take approximately 20 minutes.

The usual cost of this initial appointment is $112 and involves insurance item numbers 015.
If referred for implant assessment, further x-rays or records may be required.

More information can be obtained through our website: **www.pacificperio.com.au**

07 5559 5911
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We welcome you to our visiting practice in Cherry Street Ballina (please see map attached)

We look forward to seeing you for your first appointment with Pacific Periodontics & Implants on:

Date: _____ Time: _____

In order to assist us we would appreciate it if you would bring with you the following items:

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- **Referral letter and previous x rays (if not already sent by your dentist).**
- **Your existing manual or electric toothbrush.**

At your initial appointment we will not carry out any active treatment, except (where necessary) for the relief of pain. A detailed examination will be completed and explanation of your individual findings. We will formulate a treatment plan to manage your dental requirements. This will help us determine the number and length of appointments required as well as the professional fees involved and their associated dental insurance item numbers. This consultation will take approximately 20 minutes.

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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? _____

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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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LOCATION DETAILS

BALLINA, NSW

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Ballina NSW 2478 Australia

info@pacificperio.com.au

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