Welcome to Benowa Mansions Periodontal Practice

This form is primarily designed to alert us to any medical condition or medication that may interfere with the comfort or safety of your dental care. We will ensure that this information remains private and confidential. Please complete this form in English and feel free to ask the receptionist for assistance if required.

Mr Mrs Ms Miss Dr Other ____

First Name: _____ Middle Initials ____ **Surname**:_____

Preferred Name: _____ **Date of Birth:** ____/____/____ Gender: _____

Home Address: _____

_____ Post Code: _____

Home Phone: _____Work Phone : _____**Mobile Phone** : _____

Email Address: _____ Occupation: _____

General Dentist & Practice: _____General Medical Doctor: _____

Are you covered by a private health fund with dental extras? NO / YES
Appointment Reminders By: PHONE / SMS / EMAIL. **Correspondence By:** PHONE / SMS / EMAIL.

MEDICAL HISTORY: There are some medicines and previous or present illnesses which can modify or postpone some dental procedures. Please consider each question and ***Please Circle Correct Answer***

Emergency Contact:_____
Do you have any illness at present? NO YES If yes, please specify : _____
Are you currently taking any medication? NO YES If yes, please specify : _____

Do you have your medication with you? NO YES
Are you allergic to any medication? NO YES If yes, please specify : _____
Women, are you pregnant? NO YES If yes, due date? : _____

SMOKING HISTORY - ***Please Circle Correct Answer***
Have you ever smoked tobacco/marijuana? NO YES
If yes, are you a current smoker? NO YES Reformed Smoker? NO YES
Years smoked _____ Average per day _____ Year ceased _____

FOR YOUR PROTECTION: You have our complete assurance that at this periodontal clinic, we practice the highest level of infection control for your well being and safety. Please feel free to discuss with us privately and confidentially, any concerns you may have.

HAVE YOU SUFFERED FROM: (please circle all that apply to you or have applied to you in the past)

Diabetes	Hepatitis B/C	Cancer Therapy	Recent Life Stress
Hip Or Knee Replacements	Epilepsy	Asthma	Wear Contact Lenses
Heart Disease	Bleeding Disorders	Fainting	HIV
Rheumatic Fever	Thyroid Disorder	High Blood Pressure	Osteoporosis

Other Diseases Please specifiy: _____ Other Concerns _____
Do you believe for any reason you need prophylactic antibiotics before dental appointments? Or do you currently take/ have been advised to take prophylactic antibiotics before dental appointments? YES / NO

Please circle the number that indicates your level of apprehension about your dental visits and treatment.
Completely at Ease 0 1 2 3 4 5 6 7 8 9 10 **Petrified**

No accounts are kept in this practice, hence it is practice policy that payments be made on the day of treatment – by Cash, cheque, eftpos or major credit cards are accepted. PLEASE NOTE: Any accounts that are not settled on the day of treatment will be sent to the debt collector and you will be responsible for all collection costs, legal fees and commissions that will be added onto your account to recover the monies owing. Thank you.

Patient Signature: _____ Date: ___/___/___

Clinician's Signature: _____ Date: ___/___/___

PLEASE NOTE SECURE CCTV OPERATES THROUGHOUT THIS PRACTICE