cairns specialist dental

Dr Brian James BDSc, MDSc (Qld), FRACDS
Specialist Periodontist and Dental Implantologist

Dr Behrooz Eftekhar MDSc (Iran), DMD (Iran)
ADA Specialist Endodontist Certification

Patient Medical History

DATE / /

PERSONAL DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other

FIRST NAME | SURNAME | DATE OF BIRTH / /

ADDRESS | POSTCODE

EMAIL ADDRESS | MOBILE PHONE | HOME PHONE | WORK PHONE

EMPLOYER | OCCUPATION

EMEGENCY CONTACT | PHONE | RELATIONSHIP

REFERRING DENTIST | HEALTH FUND NAME

YOUR DOCTOR | PRACTICE NAME

MEDICAL HISTORY

Please tick any that apply to your medical history

- ☐ AIDS/ HIV exposure
- ☐ Excessive Bleeding
- ☐ Asthma
- ☐ Mental/Nervous disorder
- ☐ Fainting
- ☐ Blood disease
- ☐ Heart disease
- ☐ Prosthetic implants
- ☐ Bone disease
- ☐ Heart valve defect
- ☐ Respiratory problems
- ☐ Osteo/Prolia injections
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Cancer
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Skin Problems/Rashes
- ☐ Cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Liver disease
- ☐ Thyroid problems
- ☐ Epilepsy
- ☐ Kidney disease
- ☐ Ulcers
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Other Please state:

GENERAL HEALTH QUESTIONS*

Are you pregnant? (If yes please indicate due date) ☐ NO ☐ YES Due date:

Is personal stress a significant part of your life? ☐ NO ☐ YES Details:

Do you require antibiotic cover prior to dental treatment? ☐ NO ☐ YES Details:

Recent knee/hip/heart valve? When (MM/YY) / ☐ NO ☐ YES

Are you sensitive or allergic to LATEX? ☐ NO ☐ YES Explain reaction:

Do you have any other allergies? ☐ NO ☐ YES Explain reaction:

Smoking Status ☐ NON-SMOKER ☐ CURRENT Cigarettes per day ☐ PAST Quit date / Cigarettes per day prior to quitting

Do you currently take any medication? ☐ NO ☐ YES (Please list all medications in the space below)

Note: If you have a lengthy response, mark with an asterisk (*) and use the space provided overleaf.

▶ Please turn over page to complete this form

DENTAL HISTORY

NAME OF YOUR CURRENT DENTIST/PRACTICE | DATE OF LAST VISIT | REASON FOR VISIT

/ /

HAVE YOU HAD COMPLICATIONS FOLLOWING PREVIOUS DENTAL TREATMENT? (If yes, please explain)

Are you anxious about dental treatment? (Please tick)

Completely comfortable > 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ < Completely terrified

Have you ever had any of the following?

☐ Treatment for gum disease ☐ Root canal treatment ☐ Difficulty achieving numbness

☐ Occasional bad breath ☐ Trauma from accident ☐ Bleeding gums when brushing

☐ Reaction to anaesthetic (if yes, please explain)

☐ Crown treatment (if yes, please explain)

Do you use: ☐ Manual toothbrush ☐ Electric toothbrush ☐ Floss ☐ Piksters How often do you brush each day?

TERMS & CONDITIONS

Please read carefully the below terms and conditions, and sign.

1. I authorise the doctor or designated staff to undertake examination, x-rays, study models, photographs and other diagnostic aids as deemed appropriate in order to make a thorough diagnosis. Any associated fees will be discussed beforehand.
2. Upon such diagnosis, I authorise the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I understand that the time set aside for my appointment is important, and I make a commitment to maintain these appointments once made **I understand that failure to provide the practice with at least 48 hours notice of appointment changes or cancellation will elicit a broken appointment fee.**
4. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants/understand that **payment in full is due on the day of appointment with no exceptions.** Payment can be made via Cash EFTPOS, Bank Transfer the day before or MediPay.

DECLARATION & CONSENT

1. I declare that the above information is true and correct to the best of my knowledge.
   If there are any changes to my medical history, I will notify the treating clinician as soon as possible.
2. I have read and agree to the terms and conditions as set out above and as advised by Cairns Specialist Dental.

NAME OF PATIENT

SIGNATURE OF PATIENT | DATE

/ /

ADDITIONAL INFORMATION

Use this space if there was insufficient space for your responses on page 1 of this form.