South Eastern
Periodontics
And Implants

PATIENT INTRODUCTION FORM

TITLE: ………... FIRST NAME: ....………………………... PREFERRED NAME: ….......…….........……....

SURNAME:…………………………………………………..…….. SEX: □ MALE □ FEMALE □ OTHER

DATE OF BIRTH: ....………………….. PHONE (Mobile): ……….......…...

PHONE (Home): ....………………….. PHONE (Work): ....…………...

POSTAL ADDRESS: ....…..................

EMAIL: ....……………………………………… OCCUPATION:……………………………………

EMERG. CONTACT NAME:..................................… RELATIONSHIP:…………..………. PH: …...................................

DENTIST: ....…………..... DOCTOR: …..

REFERRED BY (please tick): □ Dentist □ Existing patient □ Other.......................................

PRIVATE HEALTH FUND: □ YES □ NO FUND NAME: ....…

DO YOU HAVE A HEALTH CARE CARD OR STUDENT CARD?: □ YES □ NO

MEDICAL SUMMARY

Do you currently or have you ever suffered any of the following? (please tick)

□ High Blood Pressure
□ Stroke
□ High Cholesterol
□ Diabetes
□ Respiratory/Lung disease
□ Cardiac/Heart disease
□ Thyroid disorders
□ Anxiety
□ Mental health disorders
□ Arthritis
□ Osteoporosis
□ Urinary/Kidney disease
□ Liver disease
□ Asthma
□ Hip or knee replacement
□ Cancer type: …………………
□ Neurological (nerve) problems
□ Excessive bleeding
□ Infectious disease eg. HIV

Do you currently or have you ever suffered from any other serious illness? □ YES □ NO

If so, please specify...…

Are you currently taking any drugs or medications? □ YES □ NO

If so, please list medications: ....…………..

Are you taking any medication for osteoporosis, or taking Fosamax or Actonel? □ YES □ NO

Do you have any allergies? (e.g, Penicillin, Latex) □ YES □ NO

If so, please specify...

Ladies, are you pregnant? □ YES □ NO If yes, date due ....………..

Do you presently or have you ever smoked? □ YES □ NO

If yes, year started .... year stopped (if applicable) .... average no. cigarettes per day ....

Type of toothbrush: □ manual toothbrush □ electric toothbrush

Type of interdental cleaner: □ floss □ interdental brush □ toothpicks □ none

Patient's signature: ....……………………………... Date: ....…

PRIVACY AND TERMS OF PAYMENT

Privacy Policy

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

We need the information set out on this form in order to provide you with effective and efficient dental services. You are entitled to access your information at any time and we will keep your information confidential. If necessary, however, we may pass your information on to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Terms of Payment

I accept responsibility for my account and understand that the fee is payable on the day. Should I be unable to pay on the day I understand that the fee is due within 30 days; If my account remains overdue it will be referred to a collection agency and/or law firm.
In the event where my overdue account is referred to a collection agency and/or law firm, I will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.
I accept full responsibility for health fund claims and rejections.
Any fees incurred by the practice for cheques not accepted by the bank may be passed to me.
I understand that if I do not attend a scheduled appointment without giving 24 hours notice of cancellation, I may incur an appointment fee.

Patient Name (or name of guardian):………………………………………………………………

Signature: …………………………………………………………..Date:………………………..