



HUNTER PERIODONTICS & IMPLANTS
MEDICAL/DENTAL HISTORY FORM

Dr / Mr / Mrs / Ms / Miss / Master

Surname: Given Names:

Name you prefer to be called:

DOB: / /

Address:

Suburb: State: Postcode:

Home Phone: Business Phone: Mobile:

Email:

Occupation: Employer:

Are you a member of a health fund with dental cover? Yes No

If yes, which fund? Member # Patient #

Emergency Contact: Phone: Relationship:

REFERRING DENTIST: PRACTICE:

MEDICAL HISTORY

GP Name: Phone:

GP Clinic: Suburb:

Rheumatic Fever: Yes No Epilepsy / seizures: Yes No

Heart Condition: Yes No Kidney Disease: Yes No

If yes, please specify heart condition: Liver Disease: Yes No

Immune Deficiency: Yes No

Bleeding Disorder: Yes No Joint Replacement: Yes No

Asthma: Yes No Steroid Therapy: Yes No

Blood thinner / antiplatelet agent: Yes No Stroke: Yes No

Blood pressure (high / low): Yes No Thyroid Disorder: Yes No

Low bone density: Yes No Are you pregnant: Yes No NA

Cancer: Yes No Covid Vaccinated: Yes No

Diabetes: Yes No

Medication list including complimentary medicines and supplements:

Table with 3 columns: Drug Name, Dose, Frequency

Medication list continued:	Drug Name	Dose	Frequency

Please list any **adverse reactions / allergies** to medications:

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Have you been hospitalized in the last 3 years? Yes No

Are you in a high risk group for HIV or hepatitis? Yes No

Anything further you wish to discuss privately with the Periodontist? Yes No

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SMOKING HISTORY Do

you smoke? Yes No

If yes: How many per day?

If applicable: I quit smoking weeks / months / years ago.

DENTAL / PERIODONTAL HISTORY

Do you have any pain / discomfort? Yes No

Do you have any cosmetic concerns? Yes No

Do you have any functional concerns? Yes No

Do you have any history / family history of periodontal disease? Yes No

DAILY ORAL HYGIENE ROUTINE

What type of tooth brush do you use? Manual Electric

How often do you brush each day?

How often do you clean between your teeth?

What do you use? Floss / Floss handle / Piksters

Thank you for completing this form. Please be assured that we keep all your information strictly confidential. By signing this form you hereby agree and acknowledge that: (i) you have accurately completed this medical history form to the best of your knowledge; (ii) you consent to any treatment agreed upon, to be carried out by the periodontists and their staff; (iii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iv) payment is due at the time of service unless other arrangements have been made.

Patient / Parent / Legal Guardian name:

Signature: Date: / /