cairns specialist dental

Dr Brian James BDSc, MDSc (Qld), FRACDS, FPFA
Specialist Periodontist

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

Dr Kavita Rana BDS, PG-Grad Cert (Gen Dent) (UQ)
DClinDent Prosthodontics UQ **Specialist Prosthodontist**

Dr Mark Atkinson BDSCG, GDipClinDent DClinDent
MFDS RCS (Edinburgh), MRACDS
Specialist Oral Surgeon including Dental Implants

Patient Medical History

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

EMERGENCY 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 smoke/vape ☐ NO ☐ CURRENT Amount per day ☐ PAST Quit date Amount per day prior to quitting

Has your GP (Doctor) prescribed Antibiotics for ALL Dental Treatment ☐ NO ☐ YES Details:

Recent knee/hip/heart valve replacement? When: ☐ NO ☐ YES Details:

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

Do you have any other allergies? ☐ NO ☐ YES
(Please list all allergies/reactions below)

Do you currently take any Prescribed Medication? ☐ NO ☐ YES
(Please list all prescribed medications 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
	X	

ADDITIONAL INFORMATION

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

CLEAR