PERIO CENTRE
periodontics & implant dentistry

MEDICAL HISTORY

Title. Title .... Surname surname .... First Name. firstname ....

Date of Birth ....

Home Phone ....

Address .... Work Phone ....

.... Mobile Phone ....

Do you have private dental insurance? Yes ☐ No ☐

Occupation ....

Company ....

Email address ....

Medicare no.. Position on Card............ Expiry.......................

Next of Kin .... Telephone ....

Name of Referring Dentist ....

CONDITION	YES	NO	REMARKS
High Blood Pressure			
Blood/Bleeding Disorders			
Rheumatic Fever			
Heart Murmur			
Heart Disease			
Stroke			
HIV positive? If yes most recent T Cell count			
Epilepsy			
Hepatitis A, B, C, D or E			
Liver Disorder			
Diabetes			
Arthritis			
Do you have a history of Tumours?			
Radiation Therapy			
Allergies to the following:			
Penicillin			
Other antibiotics			
Local Anaesthetic			
Other			
Do you have a pacemaker?			
Do you have any other implants			
Ladies, are you pregnant? Due date			
Do you smoke: if Yes, how much?			
Are you on medication? If Yes, TYPE? Please include any herbal Medications			
Have you been hospitalised in the past 2 years?			
Do you have, or have you had, any serious illness?			

Signature:____________________________ Date: ___________

Malvern East 401 Wattletree Rd Malvern East Vic 3145
All correspondence to Malvern East ABN 68 079 060 396

Tel: 03 9509 2666 **Fax:** 03 9509 5222 **Pager:** 03 9387 1000
Email: admin@cppi.com.au www.cppi.com.au

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NOTICE FOR PATIENT INFORMATION

Your Health Information and our Privacy Policy

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

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed. The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about your services and any issues affecting your treatment.

2. We may disclose your health information to other health care professionals, or require it from them if, in our judgment, is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. If any of the information we have about you is inaccurate, you may ask to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Patient signature: _____
Date: _____

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