Perio 66

Dr Sven Bohnstedt
Dr Robert Burgess
Dr Charles Snyman
Dr Geoffrey Harvey

Welcome to our practice!

Name: Dr/ Mr/ Mrs/ Ms/ Miss_____

Address:_____

Suburb:_____ Post code:_____

Date of Birth:_____ Home phone:_____

Mobile:_____ Work phone:_____

Email address:_____

Occupation:_____

Who is your Medical practitioner?_____

To which health fund do you belong to?_____

PAYMENT WILL BE EXPECTED ON THE DAY OF TREATMENT

MEDICAL HISTORY: Please answer the following

1. Are you allergic to medicines, tablets, or injections? Y/N_____
2. Do you have High/Low Blood Pressure? Y/N_____
3. Do you suffer Excessive Bleeding? Y/N_____
4. Have you had Radiotherapy/Chemotherapy? Y/N_____
5. Do you have a Heart condition/Heart valve disorder/Murmur? Y/N_____
6. Have you had Hepatitis A, B, C, HIV or other liver disease? Y/N_____
7. Do you suffer Respiratory conditions? Y/N_____
8. Do you have Rheumatic fever? Y/N_____
9. Do you have Epilepsy? Y/N_____
10. Do you have Diabetes? Y/N_____
11. Do you have Asthma? Y/N_____
12. Do you have Tuberculosis? Y/N_____
13. Do you have Thyroid Disease? Y/N_____
14. Do you have a Prosthetic Implant e.g. hip, knee, shoulder? Y/N_____
15. Do you have a Cardiac Pacemaker? Y/N_____
16. Do you have a Stomach or Digestive condition? Y/N_____
17. Do you have Bronchitis, Emphysema or other lung disease? Y/N_____
18. Do you have Anaemia, Leukaemia or other blood disorders? Y/N_____
19. Have you had a Stroke? Y/N_____
20. Have you had a Kidney Disease? Y/N_____
21. Do you Smoke or have you smoked in the past? Y/N_____
22. Do you require Antibiotic Cover before dental treatment? Y/N_____
23. Have you had an Organ or Marrow Transplant? Y/N_____
24. Women, are you pregnant? Y/N_____

Other: _____

What medication if any are you taking, including over the counter vitamins etc?_____

_____

PLEASE INFORM THE PERIODONTIST OR STAFF IF YOUR HEALTH OR CIRCUMSTANCES CHANGE AT ANYTIME.

SIGNATURE_____ **TODAY'S DATE**_____