SYDNEY PROSTHODONTIC GROUP

Dr Ben Lee | Prosthodontist
BDS (Otago) MDSc (Pros) (Syd) MRACDS (Pros)
Dr Johnson Chou | Prosthodontist
BDS (Otago) DClinDent (Pros) (Syd) MRACDS (Pros)
Dr Agnes Lai | Prosthodontist
BDS (Syd) DClinDent (Pros) (Syd) MRACDS (Pros)

New Patient Information

As a medico-legal requirement according to Dental Practice Regulations 2004 under the Dental Practice Act 2001, for us to provide correct advice and safe treatments, detailed personal and medical information is required. Please be assured that your information will be treated in the strictest confidence.

Personal Information

Title _____ Given name _____ Family name _____

Preferred name _____Date of Birth _____Gender ☐ Male ☐ Female

Telephone _____ Mobile _____ Email _____

Postal address _____Postcode _____

Preferred method of contact ☐ Telephone ☐ Mobile ☐ Email

Emergency contact (name) _____ (mobile) _____

Who may we thank for referring you to our practice _____

Medical Information

1. Please tick any past or current conditions or illnesses:

☐ Autoimmune disorder ☐ Arthritis ☐ Asthma ☐ Bleeding problem
☐ Blood pressure problem ☐ Chemotherapy/Radiotherapy ☐ Cancer/tumour
☐ Depression ☐ Diabetes ☐ Dizziness/fainting ☐ Epilepsy
☐ Heart problem ☐ Hepatitis B/C ☐ HIV/AIDS ☐ Thyroid problem
☐ Kidney problem ☐ Liver problem ☐ Osteoporosis ☐ Rheumatic fever
☐ Sinus problem ☐ Tuberculosis ☐ Vascular problem ☐ None of the above

Any other conditions/illnesses not listed above? _____

_____

2. Have you ever taken or currently using bisphosphonate/denosumab for osteoporosis? ☐ Yes ☐ No

☐ Fosamax (Plus) ☐ Alendro ☐ Actonel ☐ Skelid ☐ Aredia/Pamisol ☐ Zometa/Aclasta

☐ Didrocal/Didronel ☐ Bonefos ☐ Prolia ☐ Xgeva If yes, how long _____

3. Have you recently taken or are taking any medications (e.g. warfarin, aspirin), supplements (e.g. fish oil, garlic, Vitamin E), injections (e.g. Actonel, Prolia) or recreational drugs? ☐ Yes ☐ No

If yes, please list them all_____

_____

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Suite 301, 10 Help Street, Chatswood NSW 2067
(02) 9411 8001 info@sydpg.com.au www.sydpg.com.au

4. Are you allergic to any medications or dental materials? (e.g. penicillin, latex) _____
5. Have you ever been told you need antibiotic cover for dental treatment? ☐ Yes ☐ No
6. Have you ever had prolonged bleeding from cuts or tooth extraction? ☐ Yes ☐ No
7. Do you smoke cigarette/cigar/tobacco? ☐ Yes _____ per day ☐ No
8. If female, are you pregnant? ☐ Yes _____ months ☐ No
9. Is there anything else we should know medically about you which has not been included above? _____

Dental Information

1. Why do you seek dental care at this time? _____
2. Have you seen other dentists/specialists about this concern? _____
3. How long have you had this problem? _____
4. Have you had any problems or difficulties with previous dental treatments? _____
5. Is there anything else we should know prior to treating you? _____

Acknowledgement

I understand all personal and medical information gathered are kept confidential and can only be released to a third party with my prior approval.

I consent to dental examination and consultation and I/my guardian assume responsibility for the associated fees. I consent to Dr Lee/Dr Chou/Dr Lai to discuss my case with my referring dentist and other relevant medical personnel in my best interest enable to provide me with the best advice and management.

I consent for close up photos of my teeth to be used for case discussions, presentations and marketing purposes, without revealing my personal identity.

I am aware that full payment is required at the end of each visit by cash, bank cheque, EFTPOS, Visa or MasterCard. *Personal cheques and AMEX are not accepted.* If I choose to transfer the funds electronically via the internet, it must be transferred at least 2 working days before my appointment and I must email an online transfer receipt to the practice so that payment can be confirmed before my appointment.

I am responsible for verifying fund availability and claiming from my private health insurance, MediCare and Department of Veterans' Affairs. The practice is not responsible for the amount I can or can't claim.

I understand that at least 24 hours' notice is required to reschedule an appointment or a cancellation fee of $150 per hour may apply for failure to do so.

Signature _____ Date _____

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