

Dr Stephen Chen:  
MDSc (Melb), BDS (Malaya), FRACDS, PhD Periodontist

Dr Shayne Callis:  
M Dent (Wits), ADC, BDS(Wits) Periodontist

Dr Benedicta Wong: BDS (Otago NZ), DCD (Melb)  
Periodontist

Dr Alan Zhu: BSc (Melb), DDS (Melb), DCD (Queensland)  
Periodontist



melbourne  
periodontal  
specialists  
Periodontics and Implants

**Surname:**

**Title:**

**First name:**

**Preferred name:**

**Date of birth:**

**Email address:**

**Address:**

**Postcode:**

**Telephone - Home:**

**Work:**

**Mobile:**

**Referred by:**

**Medical GP:**

**Medical Specialist:**

Person responsible for fees (if same as above please tick):

If your visit is accountable to a third party (TAC, Workcover, VOCAT, Veterans Affairs) please provide claim number, responsible party and case manager (if applicable)

Please answer these questions fully or discuss them with the Periodontist. Information about your medical history will be kept confidential.

**Do you have any ALLERGIES?**

**(if yes please list below)**

**Current Medication** (Please list both prescription and non-prescription medication and supplements)


**Are you pregnant (or is there any possibility that you are pregnant)?**

**Do you smoke/use tobacco?**

**If Yes, how many cigarettes a day?**

**Have you smoked in the past?**

Have you ever had, or been diagnosed with any of the following? If yes, please provide details.

Heart or vascular disorders

Kidney disease

Epilepsy, fits or blackouts

Asthma

Blood pressure problems

Diabetes

Rheumatic fever

Osteoporosis or bone disorders

Heart murmur

Medication for osteoporosis

Cardiac pacemaker

Radiation therapy or chemotherapy

Gastric ulcer

Prosthetic joint replacement

Excessive bleeding or bruising

Hepatitis, jaundice or other liver problems

Anti-coagulant Medication

Persistent chest problems

Prolia Injections for osteoporosis

Please provide additional information to any questions answered "YES" and to any other conditions not listed above:

**Payment and Cancellation Policy:**

Please note payment is required on the day for all treatment.

Cancellation policy: Please provide at least 48 hours' advanced notice if you are not able to keep your appointment. Not attending an appointment without notice will attract a fee.

**Privacy:**

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

We respect 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 in 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 our 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 judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised 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, a fee will apply to these services.

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 us.

Is there anything of a confidential nature that you do not wish to write down and would like to discuss with the Periodontist?

Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

**Signed:****Date:**