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Dr Peter Barry
BDSc (Hons) Qld, MDSc (Perio) Qld, MRACDS (Perio)
Dentistry & Periodontics
PROVIDER NUMBER: 063361BW

Dr Moira Hamilton BDSc Hons (Qld)
Dentistry
PROVIDER NUMBER: 0949775A

Dr Kevin Wong BDS (Otago)
Dentistry
PROVIDER NUMBER: 2936003H

patient update form

We would like to confirm we have your information up to date so we can provide you with the best possible care. Please complete the below questionnaire with any new information and return to reception.

Your Details:

○ Prof ○ Dr ○ Mr ○ Mrs ○ Miss ○ Ms

First name: ____________________

Surname: ____________________ Date of birth: ___/___/___

Address: ____________________

____

Home number: (____) ____________________

Work number: (____) ____________________

Mobile number: ____________________

Email: ____________________

Do you wish to receive appointment reminders and special offers via SMS/email messages?

○ No ○ Yes, SMS ○ Yes, email

Emergency contact person and mobile number:

____

GP Doctors' name and location:

____

Private health insurance fund:

____

Dental and Medical History:

Please list any regular medications that you take at present including aspirin, complementary/natural/herbal medicines or vitamin supplements:

____

____

Please list any allergies or adverse reactions to any drugs or substances (including latex):

____

____

Are you being treated for any new medical conditions or problems?

○ No ○ Yes, details below:

____

Have you had any surgical procedures in the past 12 months?

○ No ○ Yes, details below:

____

Do you have, or have you had any of the following medical conditions? (tick all that apply)

- ○ Cancer (any type)
- ○ Stroke
- ○ Heart valve disorder
- ○ Heart murmur
- ○ Heart surgery
- ○ Pacemaker
- ○ Tuberculosis
- ○ Anaemia
- ○ Prosthetic implants (knee, hip, joints, etc.)
- ○ Easy bruising or excessive bleeding
- ○ Diabetes (Type I or Type II)
- ○ Anxiety or panic attacks
- ○ High or low blood pressure
- ○ Hepatitis or liver disease
- ○ Kidney disease
- ○ Radiation therapy
- ○ Stomach or digestive conditions
- ○ Transplanted organ or marrow
- ○ Bronchitis, emphysema or COAD
- ○ Contact with HIV, Hepatitis B or Hepatitis C

Are you, or is it possible that you are pregnant?

○ Not applicable ○ No ○ Yes

Do you smoke? ○ No ○ Yes, __________ per day

I understand:

- that my personal and medical information will be treated in the strictest confidence in accordance with the Privacy Act.
- that all treatment is to be paid for on the day of treatment and that no accounts are issued.
- that a fee may apply if a minimum of 24 hours notice is not given for cancellation or no-show for an appointment time.

Your signature: ____________________

Date: ______/______/______