AUCKLAND
PERIO
PERIODONTICS AND DENTAL IMPLANTS

Dr Chris **WAALKENS**
Dr Jenny **LIU**

PERSONAL DETAILS

Surname: _____ First Name: _____
Address: _____
City: _____ Postcode: _____
Phone: H: _____ W: _____ Mob: _____
Email: _____
D.O.B. D: _____ M: _____ Y: _____
Occupation: _____
Referred by: _____
Medical Doctor: _____
Spouse, Partner or Parent: _____ Phone: _____

HEALTH HISTORY

Are you in good health? _____ ☐ YES ☐ NO
Have you had any serious illness, or required hospitalization during the past two years? ☐ YES ☐ NO
Are you taking any medication now? _____ ☐ YES ☐ NO
If yes, please list: _____
Are you sensitive or allergic to any medication? _____ ☐ YES ☐ NO
If yes, please list: _____
Do you smoke cigarettes, or have you smoked in the past? _____ ☐ YES ☐ NO
Female patients, are you pregnant? _____ ☐ YES ☐ NO
Are you breast feeding? _____ ☐ YES ☐ NO
Have you ever taken fosamax or any other biphosphonate drugs? _____ ☐ YES ☐ NO

Do you have, or have you ever had any of the following? (Please tick if yes)

[ ] Heart condition
[ ] Blood condition
[ ] High or [ ] Low blood pressure
[ ] Excessive bleeding
[ ] Kidney condition
[ ] Liver condition
[ ] Hepatitis A, B, C
[ ] H.I.V. positive
[ ] Thyroid disease
[ ] Biophosphate medication
[ ] Drug history
[ ] Artificial joint/s
[ ] Diabetes
[ ] Respiratory condition
[ ] Asthma
[ ] Ulcers or ( ) Colitis
[ ] Sinus problems
[ ] Epilepsy
[ ] Steroid treatment

Any other illnesses (please list) _____

_____

PAYMENT: A fee will be charged after each appointment. We accept EFTPOS, ONLINE PAYMENTS, CASH, VISA, MASTERCARD, CHEQUE. **You will be given a quotation for the cost of treatment after your initial consultation appointment.**

Signed: _____ Date: _____
Parent's Signature if under 16 years old: _____

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