Adelaide Dental

Dr. George Mandranis & Dr. Graham Parry
Dental Surgeons

Welcome to our practice!
THIS INFORMATION IS CONFIDENTIAL and is necessary to enable us to offer you THE BEST POSSIBLE CARE.
At Adelaide Dental, we respect and protect the privacy of our patients and as such will only ask for information relevant to the treatment we may need to provide you. Thank you!

PATIENT INFORMATION

Ms Mrs Miss Mr Master Dr Other

Surname		
First Name		
Preferred		
Date of Birth		
Current Residential Address		
		Postcode:
Postal Residential Address (If different)		
		Postcode:
Occupation		
Employer		

PATIENT CONTACT INFORMATION

Phone	M:
	H:
	W:
Email	
Preferred	

Preferred method of communication:
SMS Phone Email Mail

EMERGENCY CONTACT

Name	
Relationship	
Contact number	

OTHER INFORMATION

Person responsible for your account (if yourself, please tick this box ■)

Name		Relationship	
Phone			
Address			
			Postcode

Do you have Private Health Insurance? **YES / NO**

If YES, please specify the name (e.g. BUPA)

Name	
Patient number	

Are you claiming for your treatment under a Government Dental Benefits Scheme? **YES / NO**

If yes, please circle one of the following options:
CDBS DVA Workcover MAC Other:

Please note: if you are claiming please ensure that you have the relevant letters and/or forms as payment is required at time of treatment.

How did you hear about us? *(Please circle one option below)*
Referred Yellow Pages Advertisement Internet Other:

If referred, please provide name of referrer:
Relationship to you:

Please turn over ⟶

*It is **essential** that we know about your past and present medical history. Many medical conditions may interfere with dental procedures. Please take your time and thoroughly complete the following section.*

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (Please tick as many as applies)

- ❑ Sensitivity to hot and cold
- ❑ Food trapping between teeth
- ❑ Clicking/pain in the jaw joints
- ❑ Staining of your teeth
- ❑ Discoloured fillings
- ❑ Roughness of existing fillings
- ❑ Bleeding Gums
- ❑ Bad breath
- ❑ Tenderness when eating
- ❑ Crowding of teeth
- ❑ Grinding/Clenching of your teeth
- ❑ Poorly fitted crowns/dentures

What is the main purpose of your visit today?

How long has it been since your last dental visit?

Does dental treatment make you nervous?

❑ No ❑ Slightly ❑ Moderately ❑ Extremely

MEDICAL HISTORY

Name of your Family Doctor (GP)	
Clinic	
Phone	

Have you taken any prescribed medication or dietary supplements in the last 12 months? (if YES, please list below) **YES / NO**

Allergies / Reactions? If yes, please list below: **YES / NO**

*Has **anybody** in your family history **ever** suffered from heart problems? (Please give details below)* **YES / NO**

*Have you **ever had** or are you **suffering** from any of the following? Please tick any that apply:*

- ❑ Rheumatic fever
- ❑ Diabetes
- ❑ HIV Positive
- ❑ Epilepsy
- ❑ Kidney Disease
- ❑ High cholesterol
- ❑ Asthma
- ❑ Heart Attack
- ❑ Cancer
- ❑ Tuberculosis
- ❑ High Blood Pressure
- ❑ Pace-maker
- ❑ Radiation Therapy
- ❑ Bleeding problems
- ❑ Osteoporosis
- ❑ Dizziness, fainting
- ❑ Artificial joints
- ❑ Heart rate problems
- ❑ Hepatitis A. B or C
- ❑ Respiratory problems
- ❑ Heart murmur

Do you have any disease, condition or problem not listed above? **YES / NO**

Have you had surgery or been to hospital in the last 5 years? (if YES, please give details) **YES / NO**

For Women: Are you pregnant? If yes, how many months? **YES / NO**

The information that I have provided is to the best of my knowledge true and correct and I understand that it is my responsibility to inform of any changes in my medical status.

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for the fees associated with these procedures. Therefore, I shall pay any legal costs, including solicitor and own costs, tracing costs and any collection commission incurred by Adelaide Dental as a result of my failure to pay any amount due to Adelaide Dental.

Patient/Parent/Person Responsible Signature: _____ Date: _____