Adelaide Dental

Dr. Graham Parry & Dr. George Mandranis
Dental Surgeons

Welcome back to our practice!
THIS INFORMATION IS CONFIDENTIAL and is necessary to enable us to offer you THE BEST POSSIBLE CARE. Because we haven't seen you in some time and because we care about your health status, please take you time and thoroughly complete the following update of your personal and medical information It is ***essential*** *that we know about your past and present medical history. Many medical conditions may interfere with dental procedures*

PATIENT INFORMATION			PATIENT CONTACT INFORMATION	
Ms Mrs Miss Mr Master Dr Other				
Surname			Phone	M:
First Name				H:
Preferred				W:
Date of Birth			Email	
Current Residential Address			Preferred	
		Postcode:	Preferred method of communication:	
Postal Residential Address (If different)			SMS Phone Email Mail	
		Postcode:	Referred by:	
Occupation			EMERGENCY CONTACT	
Employer			Name	
			Relationship	
			Contact number	

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**

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

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