Gawler Place Dental

Welcome!

Nick Papageorgiou & Bal Reddy's Dental Rooms

(Please take your time to fill out this form completely; all information will be handled with the highest confidentiality.)

Full Name (Mr,Mrs,Ms,Miss,Dr) ______________________________

Preferred Name ______________________________

Date of Birth ______________________________

Address (POSTAL) ______________________________

______________________________ (POSTCODE) ______________

Phone (HOME) ______________ (MOBILE) ______________

Business Name ______________ (WORK PHONE) ______________

Are you currently with a health fund (if so please state) ______________________________

Who referred you to our practice? (Please Circle)

Yellow Pages   Website   Google   Health fund   Facebook   Word of mouth (Please specify) ______________

Emergency contact (not at your address) ______________ **Telephone** ______________

Who is your doctor? ______________ **Telephone** ______________

When was your last visit to the dentist? ______________________________

Medical & Dental History

(Please tick the appropriate box)

	Yes	No	Past/Please list
Have you ever had heart trouble or high blood pressure?			
Have you ever had; rheumatic fever, diabetes, asthma, nervous disorders, anaemia or arthritis?			
Do you have or believe you may have Hepatitis, H.I.V, or any other infectious diseases?			
Are you a smoker?			
Have you any known allergies to drugs e.g. Penicillin, sulphur based, antiseptics, iodine?			
Have you ever experienced any prolonged bleeding?			
Are you allergic to Latex?			
Are you Pregnant, state how many months?			
Have you had any operations in the past year or have you had any serious illness in the past year?			
Do you have any other health problems we should know about? (Please List)			

Do you take any regular medications? (Please Circle)   **Yes**   **No**

If yes please state ______________________________

What is the purpose of your visit today? ______________________________

I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that FULL payment is due at the time of service unless other arrangements have been made.

FULL PAYMENT IS REQUIRED AT THE TIME OF CONSULTATION. IN THE EVENT THAT BAD DEBT IS ESTABLISHED THE RESPONSIBLE PARTY WILL BE HELD ACCOUNTABLE FOR THE TOTAL ACCOUNT BALANCED PLUS ANY FEES INCURRED IN COLLECTION OF THE DEBT.

If you are unable to attend, please give us 24 hours notice as last minute cancelations prevent appointments being offered to other patients. We appreciate this is sometimes unavoidable, however as a busy practice with many patients requiring our help, frequent late cancelations or failures to attend may incur a charge.

Signature; ______________ **Today's Date** ______________