Gawler Place Dental
Dr. N. Papageorgiou B.D.S (Adel)

New Patient/Medical History

Personal Details

◯ MR ◯ MRS ◯ MISS ◯ MS ◯ DR

Other: .....

First Name ..... Home Address .....

Preferred Name ..... Suburb..... Postcode .....

Last Name ..... Home Phone .....

Date of Birth ..... Work Phone .....

Occupation ..... Mobile.....

..... Email .....

How did you find out about us?

◯ Yellow Pages ◯ Website/Google ◯ Health Engine ◯ Health Fund ◯ Facebook ◯ Word of Mouth:.....

Emergency Contact

Name of Emergency Contact ..... Contact Number .....

Financial/Health Fund Information

Do you have any extras health cover? Which fund? .....

Who is responsible for payment of any accounts? ◯ Self ◯ Parents ◯ Mother ◯ Father

Medical History

Name of GP..... Contact Number of GP .....

Please tick if you have or had any of the following:

◯ Heart Problems ◯ Blood Pressure ◯ Rheumatic Fever ◯ Diabetes

◯ Anaemia ◯ Bleeding Problems ◯ Nervous Disorders ◯ Asthma

◯ Bone Disorders ◯ Arthritis ◯ Hepatitis ◯ HIV (Aids)

◯ Do you have any other infectious diseases? ◯ Are you a smoker?

◯ Are you pregnant? ◯ Have you had any previous hospitalisations?

Please briefly explain any answers you have ticked above: .....

Have you any known Allergies (e.g. Penicillin, Sulphur based, Antiseptics, Iodine)? .....

Are you taking Medications (including vitamins & Medications administered by a doctor)?.....

.....

Please turn over and complete

Dental History

Names of any other Dental Specialists you are currently receiving care from: .....

When was the last time you had a dental check-up?.....

What is your main reason for seeking Dental treatment? .....

Policy/Consent/Privacy

Our practice respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles.

Our practice collects information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your health care. We may collect information about you from third parties providing the collection of that information is necessary to provide you with health care.

If you choose not to provide us with information relevant to your care, we may not be able to provide a service to you, or the service we are asked to provide may not be appropriate for your needs.

Your medical history, treatment records, x-rays and any other material relevant to your care will be stored by the practice. The practice privacy policy sets out how you can access your records.

We respect your privacy and this information is held in the strictest confidence.

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 hour's notice.
Frequent late cancelations or failures to attend may incur a charge.

Please sign this form

- Confirming the information provided by you is complete and correct
- Confirming that you have read and understood our privacy policy
- Confirming that you have read and understood our Payments policy

Patient/Responsible Party Signature: .....

Date: .....

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