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

New patient details & medical history form

Welcome to our practice! We look forward to caring for you.
The following information helps us understand your health, individual circumstances and any additional support you may need so we can provide safe, appropriate and comfortable dental care. Please answer as accurately as possible. Your information will be treated confidentially.

1. Personal details

◯ **MR** ◯ **MRS** ◯ **MISS** ◯ **MS**

Other:

First name:

Preferred name:

Last name:

Date of birth:

Occupation:

Home address:

Suburb: **Postcode:**

Home phone:

Work phone:

Mobile:

Email:

Would you like assistance completing forms, reading written information, understanding treatment explanations, instructions or costs? ◯ Yes ◯ No ◯ Prefer not to say

Do you live in a rural or remote area? ◯ Yes ◯ No ◯ Unsure
Do you experience difficulties accessing dental appointments, transport or healthcare services? ◯ Yes ◯ No
If yes, please provide details:

Do you identify as:
◯ Aboriginal ◯ Torres Strait Islander ◯ Both Aboriginal and Torres Strait Islander ◯ Neither ◯ Prefer not to say

What is your preferred language?
Do you require an interpreter or other communication assistance? ◯ Yes ◯ No
If yes, please provide details:

Do you identify with a particular cultural, ethnic or religious background, or have any cultural needs or preferences you would like us to be aware of? ◯ Yes ◯ No ◯ Prefer not to say
If yes, what assistance or adjustments would help make your visit more comfortable?

Do you have a disability, condition or additional support need that may affect your dental treatment, communication, mobility or require assistance during your visit? ◯ Yes ◯ No ◯ Prefer not to say
If yes, what assistance or adjustments would help make your visit more comfortable?

How did you hear about our practice?
◯ Word of Mouth - *Who recommended us?*
◯ Yellow Pages ◯ Website/Google ◯ Health Engine ◯ Health Fund ◯ Facebook

2. Emergency contact

Name: **Relationship:** **Contact number:**

3. Financial & health fund information

Do you have private health insurance with extras cover? ◯ Yes ◯ No *Health fund:*

Who is responsible for payment of your accounts? ◯ Self ◯ Parent / Guardian ◯ Other
Name of responsible party (if different from patient):

Do you have concerns about the cost of dental treatment or difficulty accessing dental care due to financial circumstances?
◯ Yes ◯ No ◯ Prefer not to say

4. Medical history & general health

Your medical history is important to ensure we can provide safe dental care.

Name of GP: **GP contact number:**

Please tick any conditions you currently have or have had previously.

◯ Heart problems ◯ High or low blood pressure ◯ Rheumatic fever
◯ Diabetes ◯ Anaemia ◯ Bleeding disorders
◯ Nervous system disorders ◯ Asthma ◯ Bone disorders
◯ Arthritis ◯ Hepatitis ◯ HIV

Other medical conditions:

Are you currently pregnant? ◯ Yes ◯ No ◯ Prefer not to say

Please answer the following questions:

Do you have any known allergies or reactions to medications, latex or other substances (e.g. penicillin, sulphur-based medications, antiseptics or iodine)? ◯ Yes ◯ No

If yes, please provide details:

Are you currently taking any medications, vitamins or supplements, including medications administered by a doctor? ◯ Yes ◯ No

If yes, please provide details:

Have you had any previous hospital admissions or surgery? ◯ Yes ◯ No

If yes, please provide details:

Do you have an infectious disease or condition that we should be aware of when providing your care? ◯ Yes ◯ No

If yes, please provide details:

Have you experienced any recent changes or deterioration in your physical health, mental health, emotional wellbeing, memory or cognitive abilities? ◯ Yes ◯ No ◯ Prefer not to say

If yes, please provide details:

Do you currently use, or are you receiving support for, any of the following? (Tick all that apply)

◯ Tobacco, nicotine products or vaping ◯ Alcohol ◯ Recreational or non-prescribed drugs
◯ Other substances ◯ None ◯ Prefer not to say

Would you like to discuss anything relating to substance use or addiction that may affect your dental treatment?

◯ Yes ◯ No ◯ Prefer not to say

Is there anything else about your health that you think we should know?

5. Dental history

Are you currently receiving care from any other dental specialists? ◯ Yes ◯ No

If yes, please provide their names and specialties:

When was your last dental check-up?

What is your main reason for seeking dental treatment today?

Would you like more information about any of the following?

◯ Teeth straightening ◯ Replacing missing teeth ◯ Teeth whitening ◯ Smile makeovers

6. Privacy & practice policies

Privacy and Collection of Personal Information

Our practice respects your right to privacy and is committed to complying with the Australian Privacy Principles.
We collect personal and health information about you to provide appropriate dental care and treatment. This includes your contact details, medical and dental history, treatment records, X-rays, photographs and other information relevant to your care.
Your information may also be used for appointment management, billing, processing payments, health fund claims and communicating with you about your treatment and ongoing care.
Where necessary for your care, we may obtain or share relevant information with other healthcare providers, dental laboratories, health funds or service providers involved in your treatment.
Your information is stored securely and treated confidentially. Our Privacy Policy explains how you can access or request correction of your records and how to raise a privacy concern. A copy of our Privacy Policy is available from reception.

Payment Policy

Full payment is required at the time of consultation unless alternative arrangements have been approved by the practice.
The person responsible for payment is accountable for any outstanding fees. If an account remains unpaid and is referred for debt collection, any applicable collection costs may also be payable.

Cancellation Policy

If you are unable to attend your appointment, we ask that you provide at least 24 hours' notice.
Frequent late cancellations or failure to attend appointments may incur a cancellation fee.
Please speak with reception if you have any questions or concerns about these policies.

7. Patient declaration

By signing below, I confirm that:

The information I have provided is true and correct to the best of my knowledge.
I understand the information requested is used to assist the practice in providing safe and appropriate dental care.
I have been informed about the practice's Privacy Policy and how my personal and health information is collected, used and stored.
I have had the opportunity to ask questions about the practice's privacy and payment policies.

I understand that I should inform the practice of any changes to my medical history, medications, allergies or personal circumstances that may affect my dental care.

Patient signature: Date: