New Patient Form

GREENACRE DENTAL
Dr Chris Papastavros & Associates

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SURNAME: GIVEN NAME/S:

TITLE: ☐ MR ☐ MRS ☐ MS ☐ MISS DATE OF BIRTH:

MOBILE: HOME PHONE:

ADDRESS: POSTCODE:

EMAIL: PRIVATE HEALTH FUND:

IN CASE OF EMERGENCY, PLEASE CONTACT NAME:

RELATIONSHIP: PHONE:

GP NAME & PRACTICE: PHONE:

REASON FOR TODAY'S APPOINTMENT: ☐ CONSULT ☐ CHECKUP & CLEAN ☐ TREATMENT ☐ OTHER:__________________

IF UNDER 17 YEARS, ARE YOU COVERED BY THE MEDICARE CHILD DENTAL BENEFITS SCHEDULE? ☐ YES ☐ NO

Medical History

MEDICATIONS LIST, IF TAKING ANY, INCLUDING INFUSION & TABLETS FOR YOUR BONES:

HEART

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina
- ☐ Rheumatic fever
- ☐ Thrombosis
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Pacemaker
- ☐ Other: ________________

BONE

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Prosthetics implant
- ☐ Joint replacement
- ☐ Bone surgery
- ☐ TMJ disorder
- ☐ Other: ________________

CHEST

- ☐ Smoker
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Cystic Fibrosis
- ☐ Pleurisy
- ☐ Chest surgery
- ☐ Other: ________________

BLOOD

- ☐ Excessive/prolonged bleeding
- ☐ Anaemia
- ☐ Sickle cell
- ☐ Hepatitis/HIV/AIDS
- ☐ Other: ________________

OTHER

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Gum disease
- ☐ Stomach reflux
- ☐ Sleep apnoea
- ☐ Bruxing
- ☐ Radiation/chemotherapy
- ☐ Other: ________________

ALLERGIES

- ☐ Penicillin
- ☐ Aspirin
- ☐ Asthma
- ☐ Sinus/hay fever
- ☐ Latex allergy
- ☐ Other: ________________

SPECIAL PRECAUTIONS

- ☐ Pregnant
- ☐ Wheelchair
- ☐ Do not recline chair
- ☐ No local anaesthetics
- ☐ Translator:_____________
- ☐ Other: ________________

I have completed this form to the best of my knowledge, and will inform Greenacre Dental at a subsequent appointment if my health status has changed. Any information collected and maintained remains confidential in accordance with the State and Federal Privacy Legislation. By signing, I agree to be responsible for payment of dental services at the time the service is provided.

PATIENT/CARER'S SIGNATURE: DATE: