Welcome!

The information provided in this document ensures we are able to give you the best possible care at Adelaide Dental.

The Information is confidential and we respect the privacy of our patients, and as such will only ask for information relevant to the treatment we may provide you. Thank you!

Patient Information

Title: _____

Surname: _____

First Name: _____

Preferred Name: _____

Date of Birth: _____

Current Address: _____

Postal Address: Tick Here ( ) If As Above

_____

Phone Number: _____

Email Address: _____

Preferred Communication: [ ] Phone Call [ ] SMS [ ] Email [ ] Mail

Do you have Private Health Insurance: Yes / No

Company: _____

Patient Number Line: _____

How did you hear about us?

[ ] Personal Referral [ ] Google/Google Ads [ ] Facebook/Instagram [ ] Other

If Personal Referral, Who Referred You:

_____

Emergency Information

Name: _____

Phone Number: _____

Relationship: _____

Other Information

Job Title: _____ Employer: _____

Hobbies: _____

Dental Information

Purpose of my visit today is:

I have problems with:

[ ] Sensitivity to Hot and Cold

[ ] Staining

[ ] Yellow/Dark Teeth

[ ] Crowding of Teeth

[ ] Bleeding Gums

[ ] Food Trapping Between Teeth

[ ] Discoloured Fillings

[ ] Bad Breath

[ ] Grinding and Clenching my Teeth

[ ] Clicking/Pain in the Jaw Joints

[ ] Rough Fillings/Teeth

[ ] Tenderness when Eating

[ ] Poor Fitting Dentures

[ ] Teeth breaking down

How long has it been since your last dental visit?

The following is MOST important to me:

Please choose 3 or less only.

[ ] General Health and Well being

[ ] Look of my Smile

[ ] Chewing and Eating

[ ] Keep my Teeth for Life

[ ] Avoiding Pain

[ ] Avoiding Costs

[ ] Important Event Coming Up

[ ] Anti-aging

Please rate your smile from 1-10, with 10 being best: *Please circle*

1 2 3 4 5 6 7 8 9 10

Have you have had a bad dental experience in the past? Yes / No

Does dental treatment make you nervous?

[ ] No [ ] Slightly [ ] Moderately [ ] Extremely

Please list anything that may make you nervous about a dental visit:

Have dental anaesthetic injections worked well on you in the past? Yes / No

Medical Information

It is important that we know your past and present medical information. Many medical conditions and medications may interfere with dental procedures.

Name of your Doctor (GP): _____

Phone Number: _____

Please list any medication you have taken over the last 12 months:

- -

- -

Allergies/Reactions? If yes, please list below:

_____

Have you experienced any of the following before:

[ ] Rheumatic Fever	[ ] Kidney Disease
[ ] Epilepsy	[ ] Heart Attack
[ ] Diabetes	[ ] High Blood Pressure
[ ] Asthma	[ ] Bleeding Problems
[ ] Radiation Therapy	[ ] Artificial Joints
[ ] Dizziness or Fainting	[ ] Respiratory Problems
[ ] Hepatitis A, B or C	[ ] HIV Positive
[ ] Cancer	[ ] Osteoporosis
[ ] Heart Murmur	[ ] High Cholesterol
[ ] Pacemaker	[ ] Heart Rate Problems
[ ] Smoker	[ ] Cold Sores

Do you have any medical problem or disease not listed above?

_____

Have you had surgery or been in hospital in the last 5 years?

_____

For women, Are you pregnant? Yes / No

Referral Information

Please list the name and number of anyone you think would benefit from an appointment with our practice:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Payment Plans

[ ] Please tick this box if you would like to discuss a Payment Plan as an option for you.

Claiming

[ ] Are you claiming your dental treatment under a Government Dental Benefit Scheme? Yes / No

[ ] Are you claiming under Overseas Insurance? Yes / No

Consent Information

This is to certify that the information I have provided is to the best of my knowledge true and I understand that it is my responsibility to inform the practice of any changes in my medical status.

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 anaesthetics as indicated. 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 costs incurred by Adelaide Dental as a result of my failure to pay any amount due to Adelaide Dental.

I authorise the use and disclosure of my graphic/video images by Adelaide Dental to be used for Teaching, Marketing and Education Purposes. I may revoke this at any time, and the revocation must be received by the practice in writing.

Patient/Parent/Person Responsible Signature: _____ Date: _____

[ ] Please provide me with a copy of this form.