



Welcome!

Nick Papageorgiou | Catherine Wiering Dental Rooms

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

(Mr, Mrs, Ms, Miss, Dr) **Family Name** _____

Given Name _____ **Preferred Name** _____

Date of Birth _____

Address (Postal) _____

(Postcode) _____

Phone (Home) _____ (Mobile) _____

Email _____

Occupation _____ (Work Phone) _____

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

How did you find our practice? (Please Circle)

Yellow Pages Website/Google Health Engine Health fund Facebook Word of mouth: _____

Emergency contact _____ **Telephone** _____

Who is your doctor? (GP) _____ **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** (Please List Below) **No**
If yes please List- _____

Is there anything you would like to change about your teeth? _____

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** _____