



COSMETIC GENERAL AND IMPLANT DENTISTRY

New Patient Information

This form can be completed electronically using the latest version of Acrobat Reader and emailed to the office. Or it can be printed out and given to a staff member.

Personal Information

Title	
First Name	Surname
D.O.B	Occupation
Home / Postal Address	
Work Address	
Home Telephone	Work Telephone
Mobile	Email
Please specify preferred method of contact	
Do you have health insurance cover?	Yes No
If yes, Health Fund Name	Member Number

Referral: How did you find us?

Referred by other patient? If so, please provide their name so we may thank them			
Internet /website	Walked past	Yellow Pages	Close to work

Medical Information

Please answer these questions as fully as you can as they help us to decide the best way to treat you. If your health condition does change whilst you are a patient here please inform us.

Please tick any illness / condition you have ever had, or have now:		
Heart condition / disease	Cancer	Blood Pressure Problems
Epilepsy	Rheumatic Fever	Bleeding Problems/Haemophilia
Arthritis	Diabetes	Asthma
Sinus Problems	HIV / AIDS	Hepatitis
Kidney Disease	Liver Disease	Anaemia
Fainting	Pacemaker	Stroke
Tumours		
Any recent operations in the last 6-12 months?		
Any other illnesses?		
Are you allergic to any drugs or medication? If yes, what are they?		
Are you on any medications? If yes what are they?		
Please provide your doctors name, address and phone number		
If female and pregnant, how many months?		
Do you smoke? If so, how many per day?		

Please continue form overleaf...



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Dental / Cosmetic History

How long has it been since your last visit?		
Does dental treatment make you nervous?	No	Slightly
Extremely		
Please tick any of the following dental concerns which you are experiencing or would like to discuss:		
hot/cold sensitivity	food catching between teeth	old crowns / bridgework
previous dental treatment	whiter teeth	crooked or missing teeth
stained teeth	dental implants	gaps between front teeth
bleeding gums	grinding /clenching	silver amalgam fillings
bad breath	rough fillings	cosmetic dentistry
head /neck/jaw aches	snoring / sleep apnoea	sleep dentistry
Are you happy with your smile?		
Would you like to have whiter teeth?		
Do you have missing teeth you would like to replace?		
Are you interested in having your teeth straightened?		
Is there anything else you would like to discuss or tell us?		

Consent for Services

I consent to dental treatment which is necessary or advised to me and to which I agree to and assume responsibility for fees associated with the treatment undertaken.

I understand that 24 hours notice is required to reschedule an appointment or a cancellation fee of \$150 will apply if I fail to do so.

I am aware that payment for services is required on day of treatment.

Dr Michalopoulos would like to thank you for your response. We can ensure you that this information will remain confidential, it will not be collected or identified by government or health authorities. It will be used solely to protect ourselves and others.

Signature

Date
