GOODLIFE DENTAL STUDIO

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PATIENT INFORMATION FORM

All information gathered on this form is strictly confidential

YOUR DETAILS:

Legal Name: _____ Middle Initial: ___ Last Name:_____

Date of Birth: ____/____/_____ Gender: Male / Female

Mobile Phone: _____ Phone: _____

Address: _____Suburb: _____ State: ____ Post Code: _____

Email Address: _____Occupation: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Do you have private health insurance extras/ancillary cover for dental? Yes • No (please circle)

If Yes, which fund are you currently a member of: _____

Have you been a patient of Dr Nomikos Rakkas in the past? Yes • No (please circle)

How did you find out about us? (Circle as many as you like!)

Yellow Pages	Our Website/Google	Convenient Location
Seen the Practice	Facebook	Darwin Golf Club Brochure
Reputation	Trower road Banner	

Who recommended you? _____

Optional Question: Tell us how to make people love visiting the dentist? We want to make our patients happy!

_____

_____

DENTAL HISTORY

When was your last dental visit? _____ for _____

What is the reason for your appointment with us today? _____

_____

PLEASE TURN OVER PAGE TO COMPLETE

MEDICAL HISTORY

1) Are you taking any medications, supplements or herbal/natural remedies? Yes • No **If Yes, give details:**

_____

_____

2) Do you have an allergy of any kind (e.g certain medications, latex)? Yes • No **If Yes, give details:**

_____

_____

3) Do you smoke cigarettes / cigars / e-cigarettes? Yes • No If Yes, how many _____ cigs/day

4) Do you have or have you ever had any of the following conditions? If Yes to any, give details:

Heart Problem	Yes • No	_____
Gastric Reflux/Heartburn	Yes • No	_____
Artificial Joints/Prostheses	Yes • No	_____
Blood Disease/Bleeder	Yes • No	_____
Rheumatic Fever	Yes • No	_____
Hepatitis/HIV	Yes • No	_____
Diabetes	Yes • No	_____
Blood Pressure Problem	Yes • No	_____
Epilepsy	Yes • No	_____
Asthma or Lung Problem	Yes • No	_____
Kidney Disease	Yes • No	_____
Bone Disorders	Yes • No	_____
Radiation / Chemo Therapy	Yes • No	_____
Cancer	Yes • No	_____
Are You Pregnant (Female)	Yes • No	_____

If you have any other condition not listed above, please give details:

_____

_____

5) Who is your medical practitioner?_____ Phone: _____

By signing below you declare that the information you have provided is true and correct and that you understand it is possible that certain anonymized dental records including, but not limited to dental photographs, models and radiographs may be used for educational, research and/or marketing purposes by Goodlife Dental Studio Pty Ltd and/or Dr Nomikos Rakkas. This is a condition of treatment at this practice. If you have any concerns please discuss this with staff prior to signing.

SIGNATURE: _____

DATE: ____/____/_____

Office Use Only: Approved by Dr Nomikos Rakkas _____	U:	S: