Goodlife Dental Studio

New Patient Information Form

All information gathered on this form is strictly confidential. All * fields are required.

PATIENT DETAILS

*Full Name: ____

Title First Middle Surname

*Date of Birth: ____ /____ /____ Gender: Male / Female Occupation: _________________

*Contact Number: ______________________________________

*Address:____

Email Address: ____

Medicare Card Number: _______________________________ IRN: _____ Expiry: _______________

*Private Health Insurance? YES • NO If yes, which fund? _________________________________

EMERGENCY CONTACT DETAILS

*Name: ________________________ Phone: ___________________ Relation to you: ______________

We are not legally able to see or treat you without an emergency contact name and contact number. It may be a friend or family member that is reliable.

DENTAL HISTORY

When was your last dental visit?__________ for ____

Reason for your appointment today?____

How did you find out about Goodlife Dental Studio? (Circle as many as you like!)

Yellow Pages	Website/Google	Convenient Location	Reputation
Seen the Practice	Facebook	Previous Patient	Trower Rd Banner
Word of mouth	Other ____________________________		

Who should we thank for referring you? ____

Help us understand more about you and your dental history (tick as many as you like?)

Does your jaw click or hurt?	☐	Have you ever had teeth removed?	☐
Do you grind your teeth?	☐	Do you think you have bad breath?	☐
Have you had ortho treatment?	☐	Do you use pixters, floss, flossers etc?	☐
Do your gums bleed?	☐	Are you interested in whitening your teeth?	☐

Is there anything we can do to make your experience better/more enjoyable? _________________

____

____

MEDICAL HISTORY

Are you taking any medications, supplements or natural remedies? YES • NO **If yes, give details**

____

____

Have you had an allergy or adverse drug reaction? (ie medications, latex) YES • NO **If yes, give details**

____

____

Do you smoke? (E-cigs, cigars, vape) YES • NO If yes, how many a day? _______ per day

Do you currently have or have had in the past any of the following? **If yes, give details**

Heart Problem	YES • NO	______________________
Artificial Joints / Prostheses	YES • NO	______________________
Blood Disease / Bleeder	YES • NO	______________________
Rheumatic Fever	YES • NO	______________________
Hepatitis	YES • NO	______________________
HIV	YES • NO	______________________
Diabetes	YES • NO	______________________
Blood Pressure Problem	YES • NO	______________________
Epilepsy	YES • NO	______________________
Asthma	YES • NO	______________________
Lung Problem	YES • NO	______________________
Kidney Disease	YES • NO	______________________
Bone Disorder	YES • NO	______________________
Radiation / Chemo Therapy	YES • NO	______________________
Cancer	YES • NO	______________________
Osteoporosis	YES • NO	______________________
Thyroid Problem	YES • NO	______________________
Reflux	YES • NO	______________________
Heartburn	YES • NO	______________________
Cholesterol	YES • NO	______________________
Sinus Troubles	YES • NO	______________________
Are you pregnant / breastfeeding?	YES • NO	______________________

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

____

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. I agree to be responsible for payment of all services/treatment rendered on my behalf and on behalf of my dependent. I understand that payment is due at the time of service unless other arrangements have been made. A cancellation fee may be applied if less than 24 hours' notice is given. Our charter of Healthcare rights are available upon request. 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