johnmichalopoulos
DENTAL

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 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	

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	☐ Osteoporosis	
Any recent operations or illnesses in the last 6-12 months?		
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 and phone number		
Are you pregnant? If so, how many weeks?		
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
Is there anything 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.

By submitting this form via Email, you agree to the above 'Consent for Services'.

SUBMIT VIA EMAIL