round corner dental
olivia ignatiou & associates

Contact Details

Surname:.....First Name:.....

Preferred Name:.....Title:..... **Date of Birth**:_____/_____/_____

Home Address:.....Post Code:.....

Home Phone:.....Mobile:.....

Email:.....Occupation:.....

Emergency Contact Name:.....Relationship:.....Phone:.....

◆ Do you have private health insurance that covers dental? ☐ No ☐ Yes > Name of fund:.....

How did you hear about us? ☐ Live/Work locally ☐ Internet ☐ Local Paper

☐ Patient referral > whom may we thank for the referral? .....

Medical History *(or leave blank if you would prefer to discuss directly with your dentist).*

Do you have any allergies? ☐ Latex ☐ Penicillin ☐ Other: .....

Do you have (or have a history of) the following:

☐ High Blood Pressure	☐ Osteoporosis	☐ Epilepsy
☐ Low Blood Pressure	☐ Joint Replacement	☐ HIV/AIDS
☐ Heart Condition	☐ Arthritis	☐ Hepatitis
☐ Asthma	☐ Kidney/Liver Problems	☐ Anxiety/Depression
☐ Cancer	☐ Stroke	☐ Dementia
☐ Chemo/Radiotherapy	☐ Diabetes	☐ Other

If you ticked yes to any of the above conditions, please specify any relevant details here:

.....

◆ Do you take injections or tablets for **Osteopenia or Osteoporosis**? (i.e. Prolia injections, Actonel) ☐ Yes ☐ No

◆ Do you take blood thinners? ☐ Yes ☐ No

Do you take any other medications? If yes, please list here.....

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◆ Do you smoke or vape? ☐ Yes ☐ In the past ☐ Not at all

◆ How should we contact you for 6-monthly check-up reminders?

☐ SMS ☐ Email ☐ Letter ☐ No reminders please!

◆ Is there anything else we should know?.....

Please be assured all the information you have provided will be handled with strict confidentiality in accordance with the Privacy Amendment Act 2004 and the Health Records and Information Act 2002.
By signing this form, you hereby agree and acknowledge that: (i) you have provided accurate information to the best of your knowledge; (ii) you are responsible for payment of all services rendered on your behalf and on behalf of your dependents; (iii) payment is due at time of service unless other arrangements have been made.

Patient/Guardian's Signature: _____ Date: _____/_____/_____