Adelaide Endodontic Specialists

New Patient Form

Welcome to Adelaide Endodontic Specialists.
For our records, and especially to assist us in providing the best treatment for you, please take the time to answer the following questions as accurately as possible. Please advise if you require assistance to complete this form.

PATIENT DETAILS

Title: First Name: Last Name: Email:

Preferred Name: Date of Birth: Gender: Occupation:

Home: Work: Mobile:

Street Address: Suburb: State: Postcode:

Postal Address: Suburb: State: Postcode:

Dental Benefit Fund: Person/Third Party Responsible for Payment of Your Account, Claim/Card Number (e.g Workcover or DVA)

EMERGENCY DETAILS

Emergency Contact: Medical Doctor:

Relationship: Medical Doctor Contact Number:

Emergency Contact Number: Other Medical Specialists:

REFERRING DENTIST

Referring Dentist: Referring Dentist Location: Do you see any other Dentists or Dental Specialists:

IF UNDER THE AGE OF 18, PLEASE FILL OUT THIS SECTION

Father's Name: Contact Number: Preferred Contact Regarding your Dental Treatment:

Mother's Name: Contact Number: Relationship: Contact Number:

Form continued on next page...

SPECIALIST ENDODONTISTS

Dr Paul Heijkoop | Dr Daniel Farmer | Dr Jonathan Christo

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Adelaide Endodontic Specialists

New Patient Form (continued)

MEDICAL QUESTIONNAIRE

Please indicate by ticking the appropriate boxes if you have ever been diagnosed with, have been or are currently suffering from one of the following conditions:

- [ ] Artificial Joints
- [ ] Blood Pressure, high or low
- [ ] Heart Problems
- [ ] Prosthetic Valves or Stents
- [ ] Pacemaker
- [ ] Bacterial Endocarditis
- [ ] Stroke
- [ ] Excessive Bleeding (inc. Blood Thinners)
- [ ] HIV
- [ ] Bone Disorders (eg. Osteoporosis)
- [ ] Respiratory Problems (eg. Asthma)
- [ ] Sinus Problems
- [ ] Liver Disease (inc. Hepatitis)
- [ ] Diabetes
- [ ] Kidney Disease
- [ ] Thyroid Problems
- [ ] Stomach Problems (eg. Ulcers, Reflux)
- [ ] Nervous Disorders
- [ ] Epilepsy
- [ ] Cancer or Growths
- [ ] Previous Radiation Treatment
- [ ] Allergies (eg. Penicillin, Codeine, Latex) - Please Specify:
- [ ] Other - Please Specify:

MEDICATIONS

Please list all medications, prescribed or otherwise, that you take routinely or at present:

PREVIOUS DENTAL EXPERIENCE

Have you had any problems with dental treatment in the past? Yes [ ] No [ ]

If Yes, please explain:

OTHER RELEVANT HISTORY

Are you pregnant? Yes [ ] No [ ] If Yes, please indicate how many weeks:

Are you currently undergoing any medical investigations? Yes [ ] No [ ]

If 'Yes', please specify:

Have you been admitted to hospital or needed emergency care in the past 12 months? Yes [ ] No [ ]

If 'Yes', please specify:

Is there any other information that should be known about your health (eg. hearing aids, neck/back disorders etc.)?

Is there any issue that you would like to discuss with the Dentist in private? Yes [ ] No [ ]

To the best of my knowledge, all answers to the preceding questions are correct. I understand that it is my duty to inform the dentist should any of my medical circumstances change. I have read the Adelaide Endodontic Specialists Privacy Policy Yes [ ]

Signature:

Date: