Gladstone Park Dental
29 Rylandes Drive, Gladstone Park VIC 3043
(03) 9338 7218 (03) 9338 7218
www.gladstoneparkdental.com.au

Title (Mr, Mrs, Miss, Ms, Dr) ___________________ Surname ___________________________________

First Name ______________________________________ Date of Birth ___________________________________

Address ____ Postcode ___________

Mobile Phone ________________________Home ________________________ Work ______________________

Email Address ____

Work Place ____

Emergency Contact Person ____________________________ Phone number ____________________________

Do you have Private Insurance Fund? □ **YES** □ **NO**

If Yes, Which Fund ____

Referral Information – how did you find us?

□ Internet □ Walk In □ Yellow Pages □ Family member or Friend recommended ______________________

Have you been under the care of a medical doctor during the past two years? □ **YES** □ **NO**

If yes, for what? ____

Doctor's Name ____ Phone ___________________________________

Address ____ State _______ Postcode _______

Are you taking any medication now? □ **YES** □ **NO**

If yes, please list name and dosage: ____

Ladies are you Pregnant? If yes, how many months ___________________

Are you aware of having an allergic (or adverse) reaction to any medication or substance? □ **YES** □ **NO**

If yes, please list ____

Indicate which of the following you have had, or have at present? If yes, please tick.

□ Heart (surgery, disease, attack)
□ Stroke
□ Congenital Heart Disease
□ Heart Murmur
□ Heart Pacemaker
□ Rheumatic Fever
□ Mitral Valve Prolapse
□ Artificial Heart Valve
□ High Blood Pressure
□ Tumours/Cancer
□ Radiation Therapy
□ Chemotherapy
□ Diabetes
□ Artificial Joints (hip, knee, etc.)
□ Arthritis/Rheumatism
□ Thyroid Problems
□ Liver Disease
□ Kidney Trouble
□ Tuberculosis
□ Asthma or breathing problems
□ Epilepsy or Seizures
□ Neurological Disorders
□ Cortisone Medicine
□ Hepatitis HIV/AIDs

Do you have or had any disease, condition or problem not listed?

If yes, please list ____

Patient/ Guardian Signature ____ Date _________________