adelaide CAD
Centre for Advanced Dentistry

Dr Sravan Chunduru
Prosthodontist
DClinDent (Pros), BDS, MRACDS (Pros)

ACQUAINTANCE FORM

Welcome! To assist us in providing the best possible care, please complete the following form.

ABOUT YOU

(Mr / Mrs / Miss / Ms / Dr/ Prof / Other)

Surname:	First Name:
Name I preferred to be called:	Date of Birth:
Address: Postcode:	Home phone: Work phone: Mobile phone:
Occupation (because this often helps us explain procedures):	Email address:
Whom may we thank for referring you to us?	
Please tell us why you've been referred to us?	

In the event of an **emergency please contact**:
Name:
Telephone:
How would you like us to confirm your future appointments? (Circle one) SMS / E-mail / Phone

MEDICAL HEALTH HISTORY

Please circle yes/no to which of the following you may have had in the **past** or have at **present.**

Heart Condition (surgery/disease/attack)	yes/no	Diabetes	yes/no
Heart Murmur or Rheumatic Fever	yes/no	Allergies to anaesthetics/ penicillin/medications/latex	yes/no
High Blood Pressure	yes/no	Sinus troubles	yes/no
Arthritis/Rheumatism	yes/no	Asthma or Hayfever	yes/no
Artificial Joints	yes/no	Kidney or liver troubles	yes/no
Chemotherapy or Radiation treatment	yes/no	Anaemia or other blood disorders	yes/no
Cancer/ Tumours	yes/no	Hepatitis A B C D E	yes/no
Corticosteroid therapy	yes/no	Neurological Disorders	yes/no
HIV/AIDS	yes/no	Epilepsy or Seizures	yes/no
Thyroid problems	yes/no	Fainting or Dizzy spells	yes/no
Stomach ulcers	yes/no	Nervous/ Anxiety	yes/no

MEDICAL HEALTH HISTORY

Do you have any **ALLERGIES**? Yes/No
If yes, to what?

Do you have or have you had previously any disease, condition or problems not listed? Yes/No
If yes, please list.

Your medical doctor's name:
Medical doctor's number:
Are you taking any **medications, drugs or pills**? Yes/No
If yes, which ones?

Are you taking or have you previously taken any **bisphosphonate** medications (e.g. Fosamax, Zometa, Didronel, Relast, Boniva, Atelvia, Aclasta, Actonel, Aredia, Binosto, Skelid)?

Have you been admitted to **hospital** before? Yes/No
If yes, for what?

Do you smoke? If Yes what do you smoke & how much? ..... /day for .....years
Do you drink alcohol? If Yes how much?
Women only- are you pregnant? Yes/No - Months: Nursing? Yes/No

BILLING INFORMATION

Person responsible for paying the account (if not yourself)?

Do you have private dental health cover? If so which company?

CONSENT

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any changes in my health or medication.

I give permission the dentist and their staff to take photographs, X-rays, models and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

DENTAL PHOTOGRAPHY & VIDEO CONSENT (please cross out relevant parts if you do not consent)

In connection with dental services, I agree and consent to allow the photographs and videos taken before, during and after completion of my dental treatments to be used for dental records, research, education, public relations, patient counseling or other purposes. I further agree and consent that the photographs relating to my dental care may be published and re-published either separately or in connection with each other in dental photo albums, professional journals or dental books.

Signature:

_____ Date:

THANK YOU