|  |
| --- |
|  |

**New Patient Registration and Medical History Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title:** | **Mr. Mrs. Miss. Master. Other:** | | | | | **Given Names** | | | | | **Surname** | |  |
| **Date of Birth** | | | |  | | | | | **Occupation** | |  | |  |
| **Phone**  **Home**    **Mobile** | | | |  | | | | | **Home Address** | |  | |  |
| **Email address** | | | |  | | | | | | | | |  |
| **Health Fund** | |  | | | | **Member Number:** | | | | | **Number: (Number next to your name)** | |  |
| **Medicare Card no.** | |  | | | | | **Number: (Number next to your name)** | | | | | **Expiry:** |  |
| **Emergency contact (please provide name, relationship and phone number):** | | | |  | | | | | | | | |  |
| **Name of your GP:** | | |  | | | | | **Your Doctor’s Phone No.** | |  | | |  |
| **Your Doctor’s address:** | | | | | | | | | | | | |  |
| |  | | --- | | Internet/Website \_ Walked past \_ Yellow Pages \_ Local Newspaper \_  Patient (please provide name so that we can thank them) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **Have you ever had any of the following? Please circle those that apply:** | | | | | | | | | | | | | |
| Artificial joints | | | | | Excessive Bleeding | | | | | | Radiation Therapy to head and neck | | |
| Asthma or other lung diseases | | | | | Heart Disease-Heart attack within 3 months/Previous infective endocarditis/congenital | | | | | | Rheumatic fever | | |
| Bone conditions like Osteoporosis/Paget’s disease | | | | | Heart Disease-valve repair, coronary artery bypass within 3 months/Stent replacement within 3 months | | | | | | Rheumatoid Arthritis | | |
| Blood Pressure | | | | | Hepatitis A, B, C | | | | | | Smoking –Tobacco  - Cannabis | | |
| Blood thinning medications like Aspirin,Warfarin,Pradexa | | | | | Kidney Disease | | | | | | Thyroid problems | | |
| Cancer | | | | | Liver Disease | | | | | | Organ transplant | | |
| Diabetes-Oral Tablets/Insulin | | | | | Pacemaker | | | | | |  | | |
| Dizziness | | | | | Currently Pregnant or Breast feeding | | | | | |  | | |
| Epilepsy/Fits/Stroke | | | | | Psychiatric treatment | | | | | |  | | |
| **Allergy to Medications / Other :**  (Please specify reactions) | | | | | | | | | | | | | | |  |
| **Have you had any serious illnesses in the last 2 years**?  If yes, please provide more information. | | | | | | | | | | | | | | |  |

**List all medications you are currently using**

|  |  |  |
| --- | --- | --- |
| Name and dose of Medicine | What is the medicine for | Summary of Medical Problems |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Are you concerned with : (please tick as many as it applies)**

Your smile \_ Discolouration of your teeth \_ Gaps between your teeth \_ Crooked teeth \_ Missing teeth \_ Silver fillings \_ Previous dental treatment \_ Would like to discuss implants \_

**What is the main purpose of your visit today?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long since your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does dental treatment make you nervous? \_\_ No \_\_Yes

**Privacy Policy**: The above information is necessary to provide you with effective and efficient dental services. You are entitled to access your information at any time and we will keep your information confidential. If necessary, however we may need to pass your information on to other health practitioners or debt collection agencies.

**CONSENT FOR SERVICES**

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or

advisable, including the use of local anaesthetics as indicated and I will assume responsibility for the fees

associated with those procedures.

I understand that all dental procedures carry risk. If I still have concerns after my dentist has discussed the procedures with me, I understand I am entitled to seek a second opinion from another qualified dental practitioner.

I understand that the practice requires at least 24 hours’ notice if I need to cancel my scheduled appointment and

that a cancellation fee of $66.00 could be incurred if I fail to do so.

I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental

seminars, lectures, and publications that the dentists may author.

I am aware that payment is required on the day of treatment.

We provide as a courtesy to our patients a preventative recall program that offers a call service if you have not

been to the practice in 6 months.

**How do you wish to receive a reminder - phone call/ SMS/ email from the practice?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date of signature**