PATIENT REGISTRATION FORM

Dear Patient;
Welcome to our Practice. Please assist us in to care for you as well as possible by accurately completing this form. Please update us to any changes to your health or medications. All information collected is used to ensure your health and safety is maintained and that the best treatment possible is provided. Your personal details are used for internal purposes only and are kept ***strictly confidential.***

Title: □ Dr □ Mr □ Mrs □ Ms □ Miss □ Master Name: ___________________________________
Preferred Name: ____ Date of Birth: ____/____/____
Home Address: _____________________________ Suburb: ___________________ Post Code: ______
Home Phone: __________________ Work Phone: _________________ Mobile: ____________________
Email: ____ Occupation: ________________________
Person Responsible for Fees: ___________________________ Contact Phone: ____________________
Emergency Contact: ____________________ Relationship: _______________ Phone: _______________
Your GP Doctor: _______________________________________ Phone: ___________________________
Health Fund with Dental Insurer: ____________________ Member Number: ______________/#_____

Preferred contact method: □ SMS □ Call □ Email
Do you wish to receive a reminder call about your appointments? □ Yes □ No

How did you hear about us?
□ Internet □ Yellow Pages □ Passing By □ Local Paper □ Referred by: ________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING? Please tick and give details.

□ High Blood Pressure	□ Diabetes	□ Heart Ailment/ Surgery
□ Thyroid Problems	□ Rheumatic Fever	□ Epilepsy
□ Excessive Bleeding/ Blood Disorder	□ Tuberculosis	□ AIDS/ HIV
□ Asthma/ Chest/ Breathing Problems	□ Hepatitis A/B/C	□ Stomach/ Bowel issues
□ Kidney Disease	□ Any Hip/ Prosthetic surgery	□ Other (please describe) :

____
Do you smoke? □ No □ Yes = How many a day?_____ Would you like to stop? □ No □ Yes
Are you presently under medical care? □ No □ Yes = reason: __________________________________
Females; are you pregnant? □ No □ Yes = due on: ____________
Please list any medications/ tablets/ natural herbs that you are taking: __________________________
____
Please list any allergies that you have to any medicines or products (e.g. Penicillin, Dairy Foods, Latex):
____

I have completed this form to the best of my knowledge, & understand that failure to make a full disclosure may place ME at undue medical risk. I understand that clinical records, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to assist in my treatment, & consent to this. I also give my permission for the practice to use the above contact details to send me appointment reminders.

I am aware that this Practice requires payment in full at time of treatment

Signed: ____ Date: ____/____/____