Patient Registration & Health Summary Form

Preferred title: _____ **Date of Birth** _____ /_____ /_____

First Name_____

Last Name _____

Preferred Name _____

Address_____

Suburb _____ Postcode _____

Contact Phone Number _____

Email _____@_____

Parent / Guardian name (if applicable) _____

Carer name_____ Contact Phone Number _____

Emergency Contact Name_____

Contact Phone Number _____

Person responsible for the fees? □ Self □ Other
Name_____

Address _____

Phone number: _____

Do you have Private Health Insurance? □ Yes □ No

□ Hospital □ Dental Fund_____ Ref. Number _____

Policy Number _____

Are you eligible for the Child Dental Benefits Schedule (CDBS)? □ Yes □ No

Medicare Card Number: _____Ref #_____

Department of Veterans Affairs' Card Number (if applicable)_____

Is this consultation related to Workcover or a Work related injury or Transport Accident? □ Yes □ No

Please take care to fill out this form completely. We rely on all your information to be able to provide you with appropriate dental services.

Privacy Policy – *We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.*

Would you like to receive an appointment reminder? □ Yes □ No
□ Email □ SMS □ Phone □ Mail

Would you like to receive newsletters and notification of special offers? □ Yes □ No
□ Email □ SMS □ Phone □ Mail

Registered Association No. A0022649E ARBN 152 948 680 ABN 80 263 088 594

P.T.O.

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Medical History

To the best of your knowledge do you have or have you suffered from the following? If possible please provide approximate date of diagnosis.

□ Stroke _____ □ High Blood Pressure _____
□ Arthritis _____ □ Heart Disease _____
□ Anxiety _____ □ Digestive problems _____
□ Asthma _____ □ Osteoporosis _____
□ Respiratory _____ □ Lung disease _____
□ Diabetes _____ □ Infectious Diseases _____
□ HIV / Aids _____ □ Pacemaker _____
□ Back or neck problems _____ □ Cancer If so, where _____
□ Neurological(nerves) problems____ □ Other _____

Are you pregnant? If so, how many weeks? _____

Please state any major surgery you have had in the last five years

_____

Do you/have you received treatment for jaw related problems?

_____

Do you smoke? Yes □No □ If Yes how many per day? _____

Do you drink alcohol regularly? □ Yes □ No

Any other relevant medical history? _____

Allergies and Adverse Reactions

Do you have any allergies? Yes □ No □
Do you have any adverse reactions to drugs? Yes □ No □
If Yes please state allergy/reaction _____ Emergency Plan _____

Medicines

There are many medications that may impact upon your oral health or the treatment we plan for you. Please indicate any medications that you are currently taking or have taken recently (including natural therapies). *Alternatively a list from your GP can be attached.*

□ _____

□ _____

Are you on any blood thinners such as Warfarin or Aspirin? □ Yes □ No

Is there anything else you would like to discuss in private? □ Yes □ No

□ I agree to be responsible for all payment of fees and understand that payment is due at the time of the service.

Patient/Guardian Signature_____(if applicable)

Signature _____ Date ___/___/____