

# CONCORD DENTAL PRACTICE

## NEW PATIENT REGISTRATION FORM

### Welcome to our practice

Please take your time to answer these questions as completely as possible. This information helps us to give maximum consideration to your care as our patient. Details of your health are especially important when planning your treatment. Please note that all information given will remain strictly confidential.

### Personal Details

Surname \_\_\_\_\_

Title: Mr  Mrs  Ms  Miss  Dr

Preferred name \_\_\_\_\_

Given name \_\_\_\_\_

Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Post code

Email address \_\_\_\_\_

Contact numbers M \_\_\_\_\_

W \_\_\_\_\_ H \_\_\_\_\_

Guardian's full name (if under 18 years) \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Contact numbers M \_\_\_\_\_

W \_\_\_\_\_ H \_\_\_\_\_

Address \_\_\_\_\_

### Dental cover *(please tick if applicable)*

I have private health insurance with dental cover

Name of fund \_\_\_\_\_

Member number \_\_\_\_\_

I am a war veteran

Entitlement number \_\_\_\_\_

### Referral information

#### How did you hear about our Dental Practice?

Referred by Doctor  Referred by friend/family

Walked past  Internet

Mail out  Other

### Dental History

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

Previous Dentist \_\_\_\_\_

Address \_\_\_\_\_

#### Does dental treatment make you nervous?

No  Slightly  Moderately  Very

*We are sensitive to your feelings, and aim to provide you with the safest and most comfortable treatment possible. Please do not hesitate to tell your dentist if you have ever had any adverse dental experience that you would like to discuss, or if you are worried about any aspect of your treatment.*

#### Do any of the following dental issues concern you? *(Please tick as many as you like)*

Sensitivity to hot or cold

Staining/discolouration of your teeth

Bleeding gums

Head/neck ache

Food trapping between teeth

Discoloured or deteriorating fillings

Bad breath

Grinding or clenching of teeth

Clicking/pain in jaw joints

Sensitivity when eating

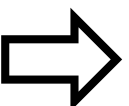
Crooked teeth or gaps between teeth

Missing teeth

Existing crowns, bridges or dentures

Appearance of your smile

*Please turn over to continue this form*



## Medical History

Name of your GP \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Contact number \_\_\_\_\_

Have you had any serious illness or operation in the past five years? Pls give date details

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

Please tick if you currently have, or have ever had any of the following medical conditions:

- High blood pressure  
 Stroke/epilepsy  
 Rheumatic fever  
 Asthma, chest or breathing problems  
 Tuberculosis  
 Hepatitis (Hep A, Hep B, Hep C )  
 AIDS/HIV  
 Diabetes  
 Excessive bleeding or blood disorder  
 Other \_\_\_\_\_

Are you pregnant? If yes, when is your due date?

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Are you currently receiving any medical treatment?  
If yes, please give details \_\_\_\_\_

Please give details of any allergies  
\_\_\_\_\_  
\_\_\_\_\_

Please give details of any medication you are currently taking \_\_\_\_\_  
\_\_\_\_\_

As a courtesy to our patients, we will remind you when you are due for your biannual checkup and clean. How would you like us to do this?

Reminder slip by post       SMS

## Your privacy

Your personal information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about the handling of your health information, please do not hesitate to raise these concerns with our practice.

## Cancellation policy

We understand that it may not always be possible for you to attend a booking you have made for various reasons. If you are unable to attend an appointment you must contact us at least 48 hours before hand, or a \$50 cancellation fee will apply to each patient that fails to attend.

To assist you in this regard, we will attempt to contact you to confirm your appointment before close of business on the day before your appointment.

## 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 have completed this document as thoroughly as possible. I understand that my failure to disclose all health related information may place myself at risk.

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

• I have read, and agree to abide by the conditions of the above cancellation policy

• I hereby consent to the use of any models, x-rays, computer images and photographs at various dental seminars, lectures and publications that the dentists may author. I understand that my personal identity will not be disclosed in relation to this.

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**DATE OF SIGNATURE**