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