New Patient Registration Form

For your convenience, and to save you valuable time, please complete the information and either Email it or PRINT OUT and bring the page(s) to our office.

Name____ D.O.B. __/____/___

Address____

____

City_________________________ Suburb__________________ Post Code___________

Phone (H)_____________ Phone (W)____________Mobile________________________

E-Mail____

Do you have Health Insurance Y / N Health Found Name______________________

Responsible Party Information (If Child under 18)

Name __________________________________ Relationship______________________

Contact Number (Home or Mobile)____

How did you find out about Us?____

Medical History

Check "N" if the question does not apply to you. Do not leave questions unanswered.

Heart conditions	Y / N
Are you required to PRE-medicate before your appointments?	Y / N
Artificial joint, vascular grafts, artificial heart valve?	Y / N
Abnormal blood pressure, excessive bleeding, or anemia?	Y / N
Breathing problems: asthma, tuberculosis, hayfever or sinusitis?	Y / N
Cancer, x-ray treatments, or chemotherapy?	Y / N
Diabetes?	Y / N

Hepatitis, jaundice, or liver disease	Y / N
Kidney problems or renal dialysis?	Y / N
HIV positive or AIDS?	Y / N
Do you smoke, use "snuff" or chew tobacco?	Y / N
Allergic reaction to medications?	Y / N
Have you ever had a major operation? If yes, please describe:	Y / N
For women: Are you pregnant?	Y / N

Dental History

Are you having pain or discomfort at this time?	Y / N
How long ago was your last visit to a dentist?	Y / N
In respect to any previous dental treatment have you: Ever had a bad experience in the dental office?	Y / N
Does food catch between your teeth?	Y / N
Are any of your teeth sensitive to heat, cold or pressure?	Y / N
Do you grind your teeth or clench your jaws?	Y / N
Do you have pain or clicking in the jaw joint around your ear?	Y / N
Do any of your teeth ache?	Y / N

Medical History Warning

Warning: Anesthetics and other medications that may be necessary in your dental treatment may interact with prescriptions, over-the-counter drugs and medications, and illicit drugs. Please make sure forms are completed accurately. These interactions may be serious and fatal! You must inform the doctor of all drugs and medications you are now, or have ever taken. You must also disclose if you are a recovering alcoholic or drug user. All information will be held in the strictest confidence and will not be disclosed without your prior approval.