PATIENT REGISTRATION FORM & MEDICAL HISTORY

Title: Mr / Mrs / Ms / Miss / Dr / Other		**Gender:**
First name:	**Last Name:**	**Preferred name:**
Home address:		**D.O.B:**
Phone (home):	**Mobile:**	**Phone (work):**
Email:	**Occupation:**	

Private Health Insurance Fund Name: □ Dental Extras Cover?	**Member #:**	**Ref#:**
Eligible for Child Dental Benefits Schedule? □ Yes □ No □ Unsure	**Medicare #:**	**Ref #:**
Department of Veteran Affairs Card # (if applicable):		

Person responsible for account: ....

Emergency contact /Guardian Name (if applicable)

Name: .... Phone: .... Relationship: ....

How did you hear about us?
□ Google □ Website □ Facebook □ Letterbox flyer □ Walked past □ Instagram
□ Other .... □ Recommended by a patient .... (so we can thank them!)

Medical History
The state of your general health may have a significant impact on your dental treatment. Please answer the following questions fully, or discuss them with your dentist, so that we can provide the very best care for you.

Name of your GP/specialist:.. Phone:...

Practice Name & Address:...

Medical History	Yes	No	Details
Are you being treated by a doctor at present?			
Are you taking any tablets or medicines at present? Importantly, are you taking any **anticoagulants** (eg. Warfarin, aspirin) or **bisphosphonates** (eg. Fosamax) for osteoporosis? Please list			
Do you normally require antibiotic cover before dental work?			
Have you had any abnormal reactions to local or general anaesthesia?			

Please turn over

Medical History	Yes	No	Details
Do you smoke?			
Are you pregnant? (if applicable)			
Are you allergic to any medicines or drugs?			
Do you have any other known allergies (including latex)			

Please tick if you have/have had any of the following conditions:

□ Rheumatic Fever	□ Diabetes	□ Stroke/fits/epilepsy	□ Steroid Therapy
□ Heart disease	□ Arthritis	□ Fainting	□ Cancer
□ Cardiac Pacemaker	□ Asthma/Lung conditions	□ Kidney disease	□ Radiation Therapy
□ Heart surgery	□ Tuberculosis	□ Thyroid disease	□ Psychological condition
□ High/low blood pressure	□ Sleep Apnoea	□ HIV/AIDS	□ Excessive Bleeding/blood disorder
□ Joint replacement surgery (Date:)	□ Hepatitis A,B,C/liver disease	□ Osteoporosis/bone disease (past & present)	□ Stomach/digestive condition

If yes to any of the mentioned medical conditions, please elaborate: ……………………………………………………………………………

Do you have any *other* medical condition and/or have you had any major surgery in the last five years? ……………………………

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Do you have current ambulance insurance? Yes / No

Dental History

Do you specifically want to discuss any of the following dental issues? (tick as many as applies)

□ Sensitivity to hot or cold	□ Holes or broken teeth	□ Oral hygiene techniques	□ Missing teeth
□ Staining of your teeth	□ Bad breath	□ Snoring	□ Crooked teeth
□ Bleeding gums	□ Discoloured fillings/teeth	□ Head/neck ache	□ Wisdom teeth
□ Food trapping between teeth	□ Grinding/clenching of your teeth	□ Clicking/pain in the jaw joints	□ Sports mouthguards

Declaration & Consent

In signing this form,

- I acknowledge that I have filled out this form to the best of my knowledge and ability, as honestly and accurately as possible.
- I understand the need to advise my dentist of any changes to my medical history in future
- I have read and understood Gisborne Family Dental's *Privacy Policy*
- I acknowledge that the practice requires at least 24 hours notice if I need to cancel an appointment
- I am aware that full payment is required on the day of treatment. Gisborne Family Dental accepts cash, Eftpos, Mastercard, Visa & Amex.

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated. I will assume full responsibility for the fees associated with those procedures. I understand diagnostic tools such as radiographs, photographs and study models may be required prior to the commencement of certain dental procedures.

Patient/Guardian (if patient is under 18 years old) ……………………………………………………………………**Date**…………………………

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