New Patient Registration Form

Title Dr / Mr / Mrs / Miss / Ms / Other

Surname _____ First name _____ Date of Birth __ / ___ / _____

Home address _____ Postcode _____

Phone (Mobile) _____ (Home) _____

Your Occupation _____ Email _____

Medicare card no _____ Patient ID _____ Expiry _____

Health fund for dental cover _____ Membership No. _____

Emergency contact _____ Relationship to patient _____ Contact No. _____

Medical Practitioner _____ Contact No. _____

MEDICAL QUESTIONS: PRIVATE AND CONFIDENTIAL

PAST/CURRENT MEDICAL CONDITIONS (PLEASE TICK)

- ○ Angina
- ○ Cardiac surgery / Pacemaker
- ○ Rheumatic fever/ heart valve
- ○ Any other heart condition
- ○ Blood thinning medication
- ○ Blood disorders
- ○ Blood pressure Low / High
- ○ Diabetes Type 1 / Type 2
- ○ Multiple Sclerosis
- ○ Osteoporosis
- ○ Rheumatoid arthritis
- ○ Asthma / COPD / Lung conditions
- ○ Thyroid disorder
- ○ Stroke
- ○ Joint replacement surgery
- ○ Jaundice or other liver diseases
- ○ Epilepsy
- ○ Kidney Diseases
- ○ Hepatitis A B or C
- ○ Steroid therapy
- ○ HIV or other blood borne viruses
- ○ Radiation / Chemotherapy
- ○ Sinus trouble
- ○ Reflux / Gastric ulcers
- ○ Depression / Anxiety
- ○ Neurological disorder
- ○ Bisphosphonate medications

Any other condition not specified_____

Current medications _____

Allergies: Medication Yes / No Details _____ Latex or rubber Yes / No Details _____

Are you currently Pregnant? Yes / No Details _____

Do you smoke? Yes / No / Ex-Smoker If Yes, how many per day ? _____

PTO....

DENTAL QUESTIONS: PRIVATE AND CONFIDENTIAL

PLEASE CIRCLE

Do you require antibiotic cover for dental treatment ? Yes / No Details _____

Have you ever had a reaction to local anaesthetic ? Yes / No Details _____

Have you ever been treated for gum disease ? Yes / No Details _____

Are you experiencing pain or a specific dental problem ? Yes / No Details _____

Are you happy with the appearance of your smile ? Yes / No Details _____

When was your last dental examination and clean / treatment ? _____

How often do you see your dental clinician ? Every 6 months / When I have a problem

How frequently do you brush your teeth ? Once a day / Twice a day / Other _____ Floss Yes / No _____

Is there anything you would like to discuss with your clinician today that isn't on the form? Yes / No

Would you like to discuss or have any of the following concerns ? (please circle)

Bad breath	Grinding/Clenching	Sensitive teeth	Cosmetic appearance of teeth
Teeth replacement	Clicking of the jaw	Bleeding gums	Loose teeth
Dentures	Implants	Dental Whitening	Snoring / Sleeping problems
Crowns / Veneers	Root canal treatment	Wisdom teeth removal	Worn / broken down teeth

How did you hear about us? Website / Location / Google / Existing patient referral name _____

Privacy Statement and Signature

I have accurately completed this patient registration to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I further acknowledge that failure to attend an appointment without notice may also result in a broken appointment fee. I authorise my dentist to take images of my teeth both before and after my treatment. I understand these images may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous. I understand that my details may be disclosed to other organizations where required by law or if necessary for debt recovery purposes.

➡ Signature _____ Date ____ / ____ / _____

Website: www.amdentalclinics.com.au

Melton : 371 High St Melton 3337

Sydenham : 536 Melton Highway Sydenham 3038