Patient Registration Form

waverley park dental care

(Please Circle)

Mr/Mrs/Ms/Miss/Mstr **First Name**: _____**Surname:** _____

Address :_____ Suburb/Town:_____ P/Code:_____

Home Ph: _____ Work Ph: _____ Mob: _____

Email: _____

Date of Birth: _____

If child, please state Father/Mother/Guardian's name: _____

Emergency Contact Name: _____ Ph: _____ Mob: _____

Do you have Private Health Insurance with extras? Yes◯ No ◯

Fund Name: _____ Policy Number: _____ Ref Number: ___

Is your child eligible for the Medicare Child Dental Benefits Schedule (CDBS)? Yes ◯ No ◯

Medicare Number: _____ Reference Number: ___

Department of Veteran's Affairs Card Number: _____

How did you find our practice? Website◯ Social Media ◯ Internet ◯ Other ◯ Family/friend_____

Medical History

Medical History: To the best of your knowledge do you have or have you suffered from the following? Please Tick

Asthma	◯	Arthritis	◯	Rheumatic Fever	◯	Neurological (Nerve) problems	◯
High Blood Pressure	◯	Anxiety	◯	Respiratory	◯	Pregnant, How many weeks?	◯
Heart Surgery	◯	Diabetes	◯	Lung Disease	◯	Other_____	
Pacemaker	◯	HIV / Aids	◯	Cancer	◯	Are you on any blood thinners	
Heart Disease	◯	Hepatitis	◯	Back or Neck problems	◯	Such as Warfarin or Aspirin?	
Stroke	◯	Digestive	◯	Osteoporosis	◯	Yes ◯ No ◯	

Are you concerned with any of the following? (Please circle)

Bad breath Bleeding gums Clenching/grinding Crooked teeth Discolouration Gaps between teeth Missing teeth

Teeth whitening Silver fillings Your smile Sleep apnoea

Allergies and Adverse Reactions

Do you have any allergies? Yes ◯ No◯ Do you have any adverse reaction to drugs? Yes ◯ No ◯

If Yes, please state allergy /reaction_____

Do you smoke? Yes ◯ No◯ If so, how many per day? ____

Do you drink alcohol regulary? Yes◯ No ◯

Do you/have you received treatment for jaw related problems? Yes◯ No◯

Please state any major surgery you have had in last 5 years_____

Medicines

There are many medications that may impact upon your oral health or treatment plan for you. please indicate any medications that you are taking or have taken recently (including natural therapies). Alternatively a list from your GP can be attached.

_____

Have you previously had Botox/Dysport or Dermal Fillers?_____ **If So, when?**_____

◯ **I agree to be responsible for all payment of fees and understand that payment is due at the time of service.**

Patient/Guardian signature_____(if applicable)

Signature_____Date____/____/_____

Do you consent to receive appointment reminders via SMS or Phone? Yes◯ No◯