Patient Registration Form

□ Mr □ Mrs □ Miss □ Ms □ Dr □ Master

First Name _____**Last Name** _____**Date of Birth**_____

Address _____**(if postal address if different please write instead)**

Suburb/Town_____**Postcode** _____

Home Phone _____ **Mobile** _____**Work Phone**_____

Email _____

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

If relevant, Carer name_____ **Phone** _____

Emergency Contact Name _____**Phone Number**_____

Do you consent for treatment to be discussed with emergency contact/guardian/carer/next of kin ? □ YES/ □ NO

Who is responsible for the account? _____

Do you have private Health Insurance? □ Yes □No Fund?_____

How did you hear about this Dental Clinic? _____

Department of Veterans Affairs Card Number _____

Is this consultation related to Work cover or a Work related injury or Transport Accident? □ Yes □ No

Terms of payment – <u>PAYMENT TO BE MADE IN FULL ON THE DAY</u>

Medical History

To the best of your knowledge do you have or have you suffered from the following?

□ High Blood Pressure _____□ Hepatitis A, B or C _____
□ Stroke _____□ Diabetes _____
□ High Cholesterol _____□ Cancer If so, where_____
□ Arthritis _____□ Asthma _____
□ Respiratory/Lung disease _____□ Urinary/Kidney problems _____
□ Cardiac/Heart Disease_____□ Neurological (nerves) problem _____
□ Dental Anxiety/phobia _____□ Sleep disturbance/apnoea
□ Osteoporosis _____□ Bowel/digestive/ulcer problems_____
□ Immunity problems _____□ Paget's Disease_____
□ Back or neck problems _____□ Mental Health _____
□ Gynaecology/Women's problems_____□ Artificial joints_____
□ Heart Valve surgery_____□ Jaw problems_____
□ Pregnant_____□ Smoker_____
□ Infectious Disease e.g. MRSA/VRE/STD/HIV _____

□ I wish to speak to the dentist about confidential medical information that I have not stated.

Allergies and Adverse Reactions

Do you have any allergies/adverse reactions? Yes □ No □ If Yes please state allergy and its affect upon you.

_____

Signed _____ Date _____

Please take the time to turn over and read our Privacy and Appointment Cancellation Policy and to list any medication that you are currently taking.

58 Campaspe St, Rochester, VIC 3561
Phone: 03) 54842010
Fax: 03) 54842505
Email: Shenai@rochesterdental.com.au

If necessary, however, we may pass your information on to other health **Privacy Policy -** We need the information set out above in order to provide you with effective and efficient dental services. You are entitled to access your information at any time and we will keep your information confidential. practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Appointment Cancellation policy – This practice requires a minimum of 24 hours' notice for appointment changes and cancellations. This provides an opportunity to offer the appointment to other patients.
If you do not provide 24 hours' notice, missed appointments will incur a cancellation fee of $60 per half an hour the first time and the total amount of the fee charted to be done on the appointment day, thereafter.

Any other medical history your Dentist should be made aware of?_____
_____

Medications

Name:	**What the medication is for**	**Dosage**