Patient registration and health summary form (Please Tick Or circle)

If you require assistance with this form, please ask a Staff member

Full Name:_____. DOB: _____.

Address: _____.

Phone : (M)_____(H)_____ (W)_____.

Email:_____.

Emergency Contact:_____. Relation:_____ Phone: _____.

Person responsible for the fees?_____ Relation:_____.

Medical Doctor:_____ Phone:_____.

Are you of Aboriginal or Torres Strait Islander origin ☐

Country of Birth:_____. Language Spoken: _____.

Do you have a Centrelink Health Care/Pension Card: Yes No

Do you have Health Insurance? Yes No Insurance Fund: _____. Ref No:_____.

Are you eligible for the Child Dental Benefits Schedule (CDBS)? Yes No

Medicare card number (Only for Child Dental Benefit Scheme): _____ Ref No:_____.

Veterans Affairs Gold Card? Yes No Card No:_____.

Community Dental Program form?: Yes No VEDS/VGDS (please circle)

Is this consultation related to Workcover/TAC a work traffic accident related: Yes No

Please take care to fill out this form completely. We rely on all your information to be able to provide you with appropriate dental services

Privacy Policy: **We collect the information set out above to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.**

Medical History: To the best of your knowledge do you have, or have you suffered from the following? If possible, please provide approximate date of diagnosis. (If Yes Please Tick)

Stroke☐ High blood pressure ☐ Low Blood Pressure ☐ Heart Conditions ☐ Bleeding/Clotting Disorders ☐

Epilepsy/Seizures ☐ Diabetes ☐ Asthma ☐ Respiratory Lung disease ☐ Back or neck problems ☐

Cancer ☐ Infectious diseases ☐ Disability/Physical/Cognitive/Neurological ☐ Mental Health ☐

If Ticked Yes, please give details _____.

_____.

Do you have any allergies? Yes No If Yes please state allergy/reaction: _____.

Medicines: There are many medications that may impact upon your oral health or the Treatment we plan for you. Please indicate any medications that you are Currently taking or have taken recently(including natural therapies). Alternatively, a list from your GP can be attached.

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Do you take Recreational Substances? *(As this may impact your dental treatment*) Yes No

Are you pregnant ? Yes No N/A If Yes, how many weeks? .

Do you smoke? Yes No If Yes how many per day .

Do you drink alcohol regularly? Yes No

Any other relevant medical history Recent Surgery or Hospitalisation? .

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Dental history

Is there anything else we should know to support your dental care? .

What is the reason for your visit today? .

When did you last visit a dentist? .

Do you/have you received treatment for jaw related problems? Y / N

Do you notice bleeding when brushing? Y / N Do you clench or grind your teeth? Y / N Do you have sensitive teeth? Y / N

Do you have any concerns or treatment that you are interested in? .

How did you find us? Website Google Facebook Walk-in Other: .

Do you consent for The Smile Centre to use your treatment photos for advertising? Y / N

Would you like to receive Email notification of special offers? Y / N

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

I have completed this Patient registration and health summary form to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check-up reminders.

Patient/Guardian Signature: **Date**: **Name**:

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED. AT ANY STAGE IF YOU HAVE CHANGED HEALTH FUNDS OR ARE PLANNING TO CLAIM THROUGH ONE OF THE FOLLOWING SCHEMES: VETERAN AFFAIRS, MEDICARE CHILD DENTAL SCHEME, VICTORIAN EMERGENCY DENTAL SCHEME OR VICTORIAN GENERAL DENTAL SCHEME, PLEASE LET ONE OF OUR STAFF MEMBERS KNOW.

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