Katoomba Dental CENTRE

# PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Surname: _____ Title: _____ Given Name: _____

Preferred name: _____ Date of Birth: _____

If the patient is a **minor** please note below the name of the parent or guardian completing this form.

Surname: _____ First name: _____

Home address: _____

Postal Address: _____

Contact Phone numbers:

Home: _____ Mobile: _____ Work: _____

Occupation: _____

Email: _____

Do you belong to a health fund? Yes No Please name: _____

How did you hear about us? (please circle)
Google Facebook Newspaper Yellow Pages Other: _____

If referred, whom may we thank for referring you to our practice? _____

## Medical History

**Have you ever had any of the following? Please answer all questions.**

| | | | | | |
|---|---|---|---|---|---|
| Heart problems | yes ○ | no ○ | Allergies to anaesthetics | yes ○ | no ○ |
| Blood pressure (High / Low) | yes ○ | no ○ | Allergies to penicillin | yes ○ | no ○ |
| Artificial joints | yes ○ | no ○ | Allergies to medications | yes ○ | no ○ |
| Rheumatic fever | yes ○ | no ○ | Explain: _____ | | |
| Circulatory problems | yes ○ | no ○ | Allergies to latex | yes ○ | no ○ |
| Radiation treatment | yes ○ | no ○ | Anaemia or other blood disorders | yes ○ | no ○ |
| Excessive bleeding | yes ○ | no ○ | Diabetes (Type 1 / Type 2) | yes ○ | no ○ |
| Excessive bruising | yes ○ | no ○ | Asthma | yes ○ | no ○ |
| Ulcers (stomach) | yes ○ | no ○ | Hepatitis A B C D E (circle) | yes ○ | no ○ |
| Sinus trouble | yes ○ | no ○ | Epilepsy | yes ○ | no ○ |
| Tumour history | yes ○ | no ○ | Liver or kidney problems (circle) | yes ○ | no ○ |

Female Patients: Are you pregnant? Yes / No How many months: _____

Have you ever had any problems or abnormal reactions to drugs or materials during dental treatment? Yes / No _____

Have you ever had or still have any serious illness? Yes / No
If yes please explain: _____

Are you taking any drugs or medication regularly? (including any herbal medication) Yes / No
If yes please explain what they are and what they are for: _____

_____

**Please continue over the page.**

**Have you ever had any of the following? Please answer all questions.**

| | | |
|---|---|---|
| Does your jaw click or hurt?..... | **yes** ○ | **no** ○ |
| Do you feel you grind your teeth?..... | **yes** ○ | **no** ○ |
| Have you ever had orthodontic treatment?..... | **yes** ○ | **no** ○ |
| Do you wear a night guard?..... | **yes** ○ | **no** ○ |
| Do you snore?..... | **yes** ○ | **no** ○ |
| Do you get headaches regularly?..... | **yes** ○ | **no** ○ |
| Have you ever had your bite adjusted?..... | **yes** ○ | **no** ○ |
| Do you bite your lips or cheek often?..... | **yes** ○ | **no** ○ |
| Do you want your Mercury Amalgam fillings removed?..... | **yes** ○ | **no** ○ |
| Do your gums ever bleed when you brush your teeth?..... | **yes** ○ | **no** ○ |
| Have you ever had gum disease?..... | **yes** ○ | **no** ○ |
| Do you experience sensitivity with hot/cold?..... | **yes** ○ | **no** ○ |
| Does floss ever tear between your teeth?..... | **yes** ○ | **no** ○ |
| Does food get jammed between your teeth?..... | **yes** ○ | **no** ○ |
| Do your teeth ever hurt when you bite hard?..... | **yes** ○ | **no** ○ |

Do you smoke? Yes / No Have you ever smoked? Yes / No

Medical Doctor/Practice:_____ Phone number:_____
Practice location: _____

Do you have any allergies? Yes / No
If yes please explain:_____
_____

How long since your last dental appointment?_____

How often do you have dental examinations?_____
Previous Dental x-rays taken: Less than 1 year ○ Longer than 1 year ○

**ACKNOWLEDGEMENT:** I understand that I am financially responsible for all charges, including any balance not paid for by my health insurance company (if I have one). Based on information provided by myself, Katoomba Dental Centre can prepare a treatment plan and cost estimate. In order to control cost of billing, estimated patient portion paid at the time of service is requested (unless prior financial arrangements have been made with this office). I understand that if this account is assigned to a debt collection agency, Katoomba Dental Centre shall be entitled to reimbursement of reasonable fees and costs of collections. I understand that a fee may be charged for broken appointments without 2 working days notice.

**CONSENT:** I the undersigned hereby authorise The Dentist to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorise The Dentist to perform dental treatment, prescribe medication, and therapy that is mutually agreed upon. I also understand that all dental procedures and the use of anaesthetic agents carry a certain risk. I understand that all procedures embody a certain amount of risk, and that I can ask for a complete recital of any possible complications.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorise disclosures of my patient record and agree to release all necessary protected health information needed to carry out treatment, payment activities and healthcare operations.

I consent to CCTV camera footage being taken in the public areas in and around the practice.

Any questions I have about patient privacy or material used in dental restorations will be answered by The Dentist and are encouraged. You consent to be contacted by any method supplied to us in the course of your treatment with us, including the contact information on this form.

My signature is my acknowledgement and consent to the above.

_____ _____
Signature Patient/Parent/Guardian Date

*Office Use Only:* Entered by: _____ Date: _____