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:_____________________________

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Please continue over the page.

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

Question	yes	no
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: ____

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How long since your last dental appointment?____

Do you have a… Pension Card ○ Concession Card ○ Health Care Card ○

<u>ACKNOWLEDGEMENT:</u> 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.

<u>CONSENT:</u> 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:**_______________