PATIENT REGISTRATION AND MEDICAL HISTORY FORM

All information on this form remains strictly confidential.
Please complete in **CAPITAL LETTERS.**

Family Name		**Title:** (circle):	DR MR MRS MS MISS MSTR		
Given Names		**Date of Birth**	/ /	**Gender**	❑M ❑F
Address					
Town/City		**State**		**Postcode**	
Home Phone *(Circle preferred)*	**Mobile**			**Work Phone**	
Email					
Occupation		**Employer**			
Emergency Contact Person	Name:				
	Phone:				
GP/Doctor	Name:			Phone:	
	Address:				
IF UNDER 18: **Guardian Details**	Name:			Phone:	
	Address:				
Insurance & Health Cover Details	Do you have a private health insurance fund? ❑Yes ❑No *Fund Name:*_____				
	Do you have a Pension/Health Card? ❑Yes ❑No				
	Do you have a DVA Gold Card? ❑Yes ❑No				

I consent to the performing of the dental and oral procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

I also consent to and understand that it may be necessary for my dentist to confer with other clinicians regarding my treatment.

I have read and understand Northwest Dental's Privacy Policy and consent to the use of my health information in this manner.

Patient / Guardian's Signature: _____Date of Signature: _____

Are you a new patient? If so how did you hear about us? Please tick the relevant box below:

☐ Phone Book ☐ Google ☐ Family Member ☐ Facebook ☐ Radio Ad ☐Oral Health Services (Parkside)
☐ Walk By ☐ Recommendation ☐ Other (please specify) _____

PLEASE TURN PAGE OVER

MEDICAL HISTORY PATIENT NAME: _____

Have you ever had any of the following? Please tick all those that apply:

❑ Anaemia	❑ Excessive bleeding	❑ Rheumatic fever
❑ Artificial joints	❑ Fainting	❑ Stroke
❑ Asthma	❑ Glaucoma	❑ Tuberculosis
❑ Blood disease	❑ Heart disease	❑ Radiation therapy
❑ Cancer	❑ Heart murmur	❑ Sinus problems
❑ Chemotherapy	❑ Heart valve problem	❑ Tumour
❑ Depression	❑ High blood pressure	❑ Nervous system disorder
❑ Diabetes	❑ Kidney disease	❑ Hepatitis: if YES, tick which type:
❑ Digestive Condition (reflux)	❑ Liver disease	❑ A ❑ B ❑ C
❑ Dizziness	❑ HIV/AIDS	❑ Respiratory problems
❑ Epilepsy	❑ Pacemaker	❑ Psychological disorders

Have you had any other SERIOUS illnesses in the last 2 years? ❑ YES ❑ NO If yes, please describe:

Please list any other illnesses /disabilities:

Please answer the following questions:

MEDICATIONS	Are you currently taking any blood thinning medication (anticoagulants)?	❑ YES ❑ NO	If yes, please list:
	Are you taking or have you taken any medications to treat osteoporosis?	❑ YES ❑ NO	
	Are you undergoing steroid therapy?	❑ YES ❑ NO	
	Are you taking <u>any other</u> prescribed or "over the counter" medications?	❑ YES ❑ NO	If yes, please list ALL (or supply printout): 1 ..... 2..... 3..... 4..... 5..... 6.....
ALLERGIES	Do you have any allergies to Penicillin or other drugs?	❑ YES ❑ NO	If yes, please list:
	Do you have other allergies, including <u>latex</u>, foods, preservatives, hayfever?	❑ YES ❑ NO	If yes, please list:
LIFESTYLE	Do you smoke?	❑ YES ❑ NO	If yes, how many cigarettes per day?
	Do you drink alcohol?	❑ YES ❑ NO	If yes, how many standard drinks per week?
	Do you take recreational drugs?	❑ YES ❑ NO	If yes, please list:
WOMEN ONLY	Are you pregnant?	❑ YES ❑ NO	If yes, how many months?
	Are you breastfeeding?	❑ YES ❑ NO	

I declare that the above information is correct at the date of signing.

Patient / Guardian's Signature: _____Date of Signature: _____

Med Hist Reprint Date	Checked by patient (Patient/Guardian Sign)	Checked by dentist (Dentist Sign)