

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 <input type="checkbox"/> M <input type="checkbox"/> F
Address					
Town/City		State		Postcode	
Home Phone <i>(Circle preferred)</i>		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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Fund Name:</i> _____				
	Do you have a Pension/Health Card? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Do you have a DVA Gold Card? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

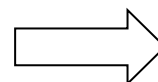
I have read and understand Northwest Dental's Privacy Policy and consent to the use of my health information in this manner.

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:

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

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)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please list:
	Are you taking or have you taken any medications to treat osteoporosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
	Are you undergoing steroid therapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
	Are you taking <u>any other</u> prescribed or "over the counter" medications?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please list:
	Do you have other allergies, including <u>latex</u> , foods, preservatives, hayfever?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please list:
LIFESTYLE	Do you smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how many cigarettes per day?
	Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how many standard drinks per week?
	Do you take recreational drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please list:
WOMEN ONLY	Are you pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how many months?
	Are you breastfeeding?	<input type="checkbox"/> YES <input type="checkbox"/> 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)