PATIENT REGISTRATION

SURNAME: _____

GIVEN NAME(S): _____

TITLE: MR ☐ MRS ☐ MS ☐ MISS ☐

NAME OF PARENT/GUARDIAN/SPOUSE: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE NO: _____

MOBILE PHONE NO: _____

HEALTH FUND: _____

USUAL DOCTOR (GP): _____

OCCUPATION: _____

WORK PHONE NO: _____

EMAIL ADDRESS: _____

NAME OF FIRM/SCHOOL: _____

BUSINESS ADDRESS: _____

WHO SUGGESTED OUR PRACTICE TO YOU?: _____

PATIENT NAME:	**MEDICAL HISTORY**
PATIENT A/C NO:	MEDICAL ALERT:

1. Have you been under the care of a medical doctor during the past two years?

   If yes, for what? _____

   Physician's Name: _____ Phone: _____

   Address: _____ Postcode: _____

2. Have you ever had a serious or long standing illness? Yes ☐ No ☐
3. Have you ever had a heart condition? Yes ☐ No ☐
4. Have you ever had rheumatic fever? Yes ☐ No ☐
5. Are you at present under medical treatment? Yes ☐ No ☐
6. Are you taking any medicine or tablets? Yes ☐ No ☐
7. Have you ever experienced any prolonged bleeding? Yes ☐ No ☐
8. Do you have a heart pacemaker? Yes ☐ No ☐
9. Do you have any artificial joints? Yes ☐ No ☐
10. Do you suffer from hay-fever or sinus trouble? Yes ☐ No ☐
11. Have you any known allergies or had any reaction to drugs? Yes ☐ No ☐
12. Have you ever had deep X-ray therapy or chemotherapy? Yes ☐ No ☐
13. Is there any other medical matter you wish to speak to the dentist about in private? Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____