

Patient Registration & Medical History Form

Please complete the following questions regarding your personal details and medical history. The questions are designed to identify factors that may influence the delivery of your dental care. All personal information is treated with complete confidentiality and in accordance with the Privacy Act 1988. Please ask Reception if you would like to access the Privacy Policy.

Personal Details

Title (*please select one*): Dr Prof Mr Mrs Ms Miss Mstr

Given Names: _____ Preferred Name: _____

Surname: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone no: _____ Mobile no: _____

Email Address: _____

Occupation: _____ Date of Birth (DD/MM/YYYY): _____

Emergency Contact Name: _____ Contact Phone no: _____

Do you have Private Health Insurance?: Yes No

Health Fund Name: _____ Member number: _____

If under 18 only – Medicare details: Full first name: _____

Medicare number: _____ Medicare position: _____

Do you have a Pension or Healthcare Card?: Yes No

Veterans Affairs Number (*if applicable*): _____ DVA card colour: _____

NSW Seniors Card Number (*if applicable*): _____

How did you find out about Koorringal Dental? (*please select 1 option below*)

- Walking by/Signage Health Fund Referral Existing patient Event
 Health Professional Referral Google Social Media Flyer

If you were referred by an existing patient, please write the name of the referrer below:

First name: _____ Surname: _____

Any of your immediate family attend our practice? Yes No / If yes, family name?: _____

Do you have any concerns about your dental health? Or anything about your smile you want to change? If yes, what are they?: _____

How would you like to be contacted for appointments? (*check all applicable*) SMS Phone Call

PLEASE TURN OVER PAGE TO COMPLETE MEDICAL DETAILS

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Confidential Medical History

The state of your health may have a significant effect on your dental care. It is important to answer the below questions as completely and honestly as possible.

Please indicate if you have any of the following:

	Yes	No		Yes	No
Rhematic Fever:	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder:	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker:	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>
Heart (Cardiac) Issues:	<input type="checkbox"/>	<input type="checkbox"/>	HIV-positive:	<input type="checkbox"/>	<input type="checkbox"/>
Heart (Cardiac) Surgery? Year:_____	<input type="checkbox"/>	<input type="checkbox"/>	Depression or other mental illness?:	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition: Murmur/Angina?:	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder?:	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition: Family history under 65 years old?	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy:	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking blood thinning medication?:	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: If yes, which type?:	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Disorder:	<input type="checkbox"/>	<input type="checkbox"/>
Currently undergoing Chemotherapy?:	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or Liver Disease:	<input type="checkbox"/>	<input type="checkbox"/>
Currently undergoing Radiation?:	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease (including Goitre):	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis or low bone density:	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth:	<input type="checkbox"/>	<input type="checkbox"/>
Taking any medications for osteoporosis?:	<input type="checkbox"/>	<input type="checkbox"/>	Snoring:	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, hay-fever or sinus? If yes, please specify:_____	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnoea: If yes, do you use a CPAP Machine?:_____	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting?:	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Ulcer:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: (Circle which type) Type 1 / Type 2	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Disorder/Reflux?:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Family history under 65 years old?:	<input type="checkbox"/>	<input type="checkbox"/>	Surgery in last 6 months?:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis: If yes, which type:_____	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?:	<input type="checkbox"/>	<input type="checkbox"/>
Immune system disorder?:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify your due date:_____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to any food or substances:	<input type="checkbox"/>	<input type="checkbox"/>	Currently breastfeeding?:	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please specify:_____	<input type="checkbox"/>	<input type="checkbox"/>	Undergone Joint Surgery?:	<input type="checkbox"/>	<input type="checkbox"/>
Adverse reactions to local or general anaesthetic?:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which joint?:_____Year:_____	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to latex?:	<input type="checkbox"/>	<input type="checkbox"/>	Currently on any medication?:_____	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any medication?:_____	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which medications?:_____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a difficult tooth extraction?:	<input type="checkbox"/>	<input type="checkbox"/>	Any other medical condition?:_____	<input type="checkbox"/>	<input type="checkbox"/>
Before dental treatment, are you required to take antibiotic prophylaxis?:	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?: If yes, for years:_____ How many per day?:_____	<input type="checkbox"/>	<input type="checkbox"/>

When was your last dental visit? _____

What medical practice do you attend? _____ Phone no.: _____

I understand that failure to complete the medical history information completely and honestly may place myself and others at medical risk.*

I have accurately completed this medical history form to the best of my knowledge.*

I hereby give my authority for any treatment agreed upon by me, to be carried out by the Dentist and their support team, and I assume full financial responsibility for said treatment.*

I would like to be kept informed of information regarding current and new services, new or updated practice information and dental techniques that may affect my next visit.

Patient / Guardian signature: _____ Date: _____