Patient Registration Form

Title_____ **First Name** _____ **Last Name** _____

Preferred Name: _____**Date of Birth**_____ **Gender**_____

I identify as: □ **Aboriginal** □ **Torres Strait Islander** □ **Prefer not to say** □ **None**

Address _____**(if postal address is different please write instead)**

Suburb/Town_____**Postcode** _____

Home Phone _____ **Mobile** _____**Work Phone**_____

Email _____ **Occupation**_____

If child, please state carers name _____**Relationship to patient:** _____

Emergency Contact Name _____**Phone Number**_____

Do you consent to treatment being discussed with emergency contact/guardian/carer/next of kin? □ **YES** □ **NO**

Who is responsible for the account? _____ **Dental Private Health Fund Name:** _____

Department of Veterans Affairs Card Number (if any) _____

Is this consultation related to Work cover or a Work-related injury or Transport Accident? □ **YES** □ **NO**

Terms of payment – <u>PAYMENT TO BE MADE IN FULL ON THE DAY</u>

Please tick and add in relevant information.

	High Blood Pressure		Hepatitis A, B or C
	Stroke		Diabetes
	High Cholesterol		Cancer If so, where
	Arthritis		Asthma
	Respiratory/Lung disease		Urinary/Kidney problems
	Cardiac/Heart Disease		Neurological (nerves) problem
	Dental Anxiety/phobia		Sleep disturbance/apnoea
	Osteoporosis		Bowel/digestive/ulcer problems
	Immunity problems		Paget's Disease
	Back or neck problems		Mental Health
	Gynaecology/Women's problems		Artificial joints
	Heart Valve surgery		Jaw problems
	Pregnant		Epilepsy
	History of Fainting		Hearing/vision or speaking impairment
	Infectious Disease e.g., MRSA/VRE/STD/		Mobility impairment
	Intellectual Disability/Spectrum Disorder		Smoker (if so, how many)
	I wish to speak to the dentist about confidential medical information that I have not stated.		

Signed _____ Date _____

Please turn over to list allergies and medications.

Allergies and Adverse Reactions
Do you have any allergies/adverse reactions? Yes □ No □ If yes, please state allergy and its affect upon you.

_____

Any other <u>medical history</u> your Dentist should be made aware of? _____

_____

Medications	**What the medication is for**	**Dosage**

How did you hear about us? (Please circle)

Facebook Google Local paper School newsletter Website Phonebook Pamphlet

Patient referral (Who? We would love to thank them) _____

Other (please specify)_____

Privacy Policy - We need the information set out above in order to provide you with effective and efficient dental services. You are entitled to access your information at any time, and we will keep your information confidential. If necessary, however, we may pass your information on to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Cancellation Policy: We understand that you may need to reschedule your appointment due to an emergency or family circumstances that cannot be avoided. Our dentists have a good reputation, which means that they are in great demand. So, when a patient does not show up to an appointment, they are preventing another patient from being able to be seen.

We send our courtesy reminders 2 weeks and 2 business days prior to your appointment. In case of needing to reschedule / cancel your appointment, we require 48 hours' notice. Where less than 48 hours have been provided prior to cancelling or you have failed to attend your appointment, you will incur a cancellation fee of $100 the first time. **If a patient repeatedly cancels their appointment or does not show up or reschedules without enough notice, we may ask to place a non-refundable deposit of $150.00 to secure your appointment.**

I confirm that I have read the above, understand the practice policy, and will give 48 hours' notice if I am unable to attend my appointment.

Signed _____ Date _____