THE DENTAL SUITES

Shop 2 / 385 Belmore Road
Balwyn VIC 3103

Telephone (03) 9857 9966
www.thedentalsuites.com.au

Patient Registration and Medical History Form

Welcome to The Dental Suites. Please fill in all blank lines accordingly, and please tick all the appropriate boxes. If the patient is under 18 years of age, a parent or an adult guardian is required to complete this form.

Patient:

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐Master

First name _____

Surname_____

Date of birth_____

Current address_____

Suburb_____ Post code_____

Telephones: Home _____ Mobile _____

Work_____ Occupation_____

Email _____

If not the patient, the person filling in this form is_____

The relationship of this person to the patient is_____

Name of person responsible for the account is _____

The relationship of this person to the patient is_____

In an emergency, the person to contact is_____

The telephone number of this person is_____

How did you hear about our practice?_____

Patient/Guardian Initial_____ Date_____

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What is the reason for the patient's visit today? (please tick appropriate boxes)

☐ Check-up	☐ Toothache	☐ Broken tooth
☐ Broken filling	☐ Missing tooth	☐ Bleeding gums
☐ Receding gums	☐ Swelling	☐ Sensitive tooth
☐Teeth whitening	☐ Smile makeover	☐ Cosmetic issues
☐ Wisdom tooth	☐ Tooth extraction	☐ Jaw joint issues
☐ Clenching teeth	☐ Grinding teeth	☐ Headaches
☐ Sleeping problems	☐ Snoring	☐ Breathing issues
☐ Crooked teeth	☐ Crowded teeth	☐ Bite problems
☐ Myobrace	☐ Braces	☐ Invisalign
☐ Tongue tie	☐ Lip tie	☐ Others

If others, please elaborate_____

_____

When did the patient visit a dentist last?_____

Does the patient usually have regular dental check-ups? ☐ Yes☐ No

If yes, how often?_____

How often does the patient brush and floss his/her teeth?_____

Is the patient happy with the appearance/function of his/her teeth?_____

_____

Is there anything about dentistry that bothers the patient? _____

_____

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The patient's regular medical doctor is_____

Doctor's address and telephone number_____

_____

Does the patient have or ever had any of the following conditions?

☐ Heart disease	☐ Heart attack	☐ Heart murmur
☐ Rheumatic fever	☐ Pacemaker	☐ Congenital heart defects
☐ Artificial heart valve	☐ Mitral valve prolapse	☐ Chest pain
☐ High blood pressure	☐ Stroke	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Kidney disorders
☐ Liver disorders	☐ Hepatitis	☐ Arthritis
☐ Rheumatism	☐ Thyroid disorders	☐ Stomach ulcers
☐ Mouth ulcers	☐ Cold sores	☐ Artificial joint (hip, knee)
☐ Blood transfusion	☐ Blood disorders	☐ Epilepsy / seizures
☐ Tumours / cancers	☐ Radiotherapy	☐ Chemotherapy
☐ Fainting / dizzy spells	☐ Psychological issues	☐ Neurological problems
☐ Latex allergy	☐ Penicillin allergy	☐ Allergy to anaesthetic
☐ Sinusitis	☐ Hay fever	☐ Bruises / bleeds easily

☐ Family history of heart disease

If yes to any of the above, please elaborate_____

_____

Other medical conditions_____

For Women: are you pregnant? ☐ Yes ☐ No

If yes, how many weeks?_____Are you nursing?_____

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Please tick if the patient may have or have had the following conditions:

☐ Creutzfeldt-Jakob Disease ☐ Hepatitis B or C ☐ AIDS / HIV

If yes to any of the above, please elaborate_____

Medications that the patient is taking (please indicate name, purpose, dosage and frequency of each):

☐Antibiotics_____

☐Heart or Blood Pressure medication_____

☐Hormone Replacement Therapy_____

☐Diabetes medication_____

☐The contraceptive pill_____

☐Cancer medication or therapy_____

☐Arthritis medication or creams_____

☐Anti-inflammatories, e.g. Nurofen, Ibuprofen, Voltaren_____

☐Asthma medication or inhaler_____

☐Pain killers, e.g. Aspirin, Panadol, Codeine_____

☐Bisphosphonates, e.g. Didronel, Bonefos, Fosamax, Actonel_____

☐Natural therapies_____

☐Nicotine Replacement Therapy_____

☐Other medications_____

Is the patient allergic to anything?_____

Does the patient smoke? ☐ Yes ☐ No If yes, how many per day?_____

Does the patient drink alcohol? ☐ Yes ☐ No If yes, how much?_____

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Privacy Policy - We need the information set out above in order to provide you with safe, effective and efficient dental services. You are entitled to access your information, but we will keep them confidential. If necessary, 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.

Terms of payment - The Dental Suites accepts payments in cash, Eftpos, Visa, or Mastercard. The fees charged are payable on the day. Should the account be overdue, an account keeping fee may be incurred to the person responsible for the patient's account. If the account is referred to a debt collection agency or solicitors, this person may be held liable for the costs of such collection plus interest. We are not affiliated with any private health fund. Health fund claims and rejections are the responsibility of the patient/guardian. Any fees incurred by the practice for cheques not accepted by the bank may be passed on to the patient/guardian. Payment plans are only available for selected cases.

Disclaimer - Dentistry is not exact science, and the outcome of every dental treatment depends on multiple factors, such as the medical health of the patient, the level of patient compliance, etc. We will always explain the risks and possible complications involved for each procedure. However, some of them are not foreseeable. For this reason, dental diagnoses and procedures cannot be guaranteed for perfection and success every time. Nevertheless, our team will engage every effort possible to achieve the highest standard of results within each patient's capacity.

Consent - By signing this form, I, the patient/person responsible for the patient, have read and understood all the information stated above. I have also filled in this form to the best of my knowledge and ability, as honestly and accurately as possible. Therefore, I give my consent for The Dental Suites to look after the patient for his/her oral health needs.

Patient/Guardian Signature_____

Date_____