DONCASTER HILL DENTAL
Our continuous care for your health & smile

Patient Registration Form

Title:	Surname:	Given name:	Preferred name:
Address:		Suburb:	Postcode:
Date of birth:	Email:		
Phone (M):	Phone (W):	Phone (H):	
Occupation:	Dental Health fund:		
Person responsible for payment:			

How did you hear about our practice? *Please circle*

Google	Facebook	WOMO	Advertisement	Signage	Yellow pages (0nline/book)
Word of mouth (name):			Our Website	Flyers	Aussietip/others

Medical History

Please tick if the answer is yes- current or history of

□ Heart disease
□ Asthma
□ Prosthetic heart valve
□ Hepatitis (A/B/C)
□ Thyroid disease
□ Dry mouth
□ Artificial joints
□ Heart attack
□ Epilepsy
□ Cardiac pacemaker
□ AIDS/HIV
□ High blood pressure
□ Mitral valve prolapse
□ Lung disease
□ Arthritis
□ Cancer
□ Depression
□ Bone disease
□ Stroke
□ Radiotherapy
□ Diabetes (type I or II)
□ Smoking
□ Heart murmur
□ Low blood pressure
□ Liver disorder
□ Osteoporosis
□ Chemotherapy
□ Sinus problem
□ Bisphosphonate medications
□ Kidney disorder
□ Pregnant
□ Bleeding disorder

Other medical conditions:_____

Medications:_____

Allergic to penicillin? ○Yes/ No ⦿

Other allergies:_____

Medical GP Doctor name:_____

Telephone number:_____

Medical clinic address:_____

Dental History

Last dental visit: _____ years _____months

Are you concerned about or experiencing any of the following dental problems? *Tick all that are applicable*

□ sensitivity to hot or cold
□ stained teeth
□ discoloured teeth
□ teeth grinding
□ existing crowns, bridges or dentures
□ missing teeth
□ silver fillings (amalgam)
□ food trapping between teeth
□ discoloured fillings
□ bleeding gums
□ head/neck ache
□ ability to eat
□ crooked teeth
□ pain when chewing/eating
□ chipped or rough fillings
□ bad breath
□ clicking or pain in jaw joints
□ gaps between your teeth
□ crowded teeth

What is the main purpose of your visit today?

_____

Do you wish to discuss whitening your teeth with us? ⦿ Yes/ No ◯

Would you like to receive our e-newsletter? ⦿ Yes/ No ◯

Payments for services are required on the day of treatment, unless otherwise discussed with by the treating dentist. We offer instant claiming of major health funds through Hicaps facility as well as accept credit card and cash.

All information disclosed in this form will be kept confidential and treated with professional discretion in compliance with any relevant privacy legislations.

All responses in this form are accurate and true to the best of my knowledge. This form is intended for informative purposes only and does not bind me to any treatment without further consent.

Signed:_____ **Date:_____**