Patient Registration Form

The Dental Gallery
3 Newminster Way
Point Cook Vic 3030
T 9395 8338

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

Preferred title: □ Mr □ Mrs □ Ms □ Dr □ Master □ Miss □ No title

First Name _____ Last Name _____

Preferred Name _____

Address _____

Suburb/Town_____Postcode _____

Home Phone _____ Mobile _____

Work Phone _____ Email _____

Date of Birth _____

How did you find out about our practice _____

How would you like to receive an appointment reminder?
□ Email □ SMS □ Phone □ Mail

Are you happy to receive practice info through email? □ Yes □ No

If you are under 18 years of age, please state Father / Mother / Guardian's name
_____

If relevant, Carer name_____ Phone _____

Emergency Contact Name _____

Phone _____ Mobile _____

Who is responsible for the account? _____

Are you eligible for the Child Dental Benefits Schedule (CDBS)? □ Yes □ No

Department of Veterans Affairs' Card Number _____

Is this consultation related to Workcover or a Work related injury or Transport Accident?
□ Yes □ No

Privacy Policy – We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. 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 Gallery accepts payments in cash, Eftpos, Visa and Mastercard. The fees are charged and payable on the day. We are not affiliated with any private health fund, therefore health fund claims and rejections are the responsibility of the patient

Disclaimer – Dentistry is not an exact science, and outcome of every dental treatment depends on multiple factors, such as the medical health of the patient. We will always explain the risks and possible complications involved for each procedure. However, some are unforeseeable. For this reason dental diagnosis and procedures cannot be guaranteed. Nevertheless, our team will engage every effort possible to achieve the highest standard of results.

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 Gallery to look after the patient for his/her dental needs

Signed _____ Date _____

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Patient's Family Doctor: _____

Address_____

Telephone_____

- Please answer the following to allow us to find out a little more about your dental health:

What is the reason for your visit today? _____

When was your last visit to a dentist? _____

Do you usually have regular dental check-ups? _____

How often do you brush and floss your teeth? _____

Do you smoke? _____

Is there anything about dentistry that bothers you? _____

Are you happy with the appearance of and the way your teeth function? _____

- Please tick the boxes if you have or ever had the following medical conditions:

☐ Heart disease	☐ Heart attack	☐ Heart murmur	☐ Congenital heart defects
☐ Rheumatic fever	☐ Artificial heart valve	☐ Mitral valve prolapse	☐ Pacemaker
☐ 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	☐ Fainting / dizzy spells
☐ Tumours / cancers	☐ Radiotherapy	☐ Chemotherapy	☐ Psychological problems
☐ Neurological problems	☐ Latex allergy	☐ Penicillin allergy	☐ Allergy to anaesthetic
☐ Sinusitis	☐ Hay fever	☐ Bruises / bleeds easily	☐ Family history of heart disease
☐ Headaches / migraines	☐ Jaw joint concerns	☐ Grinding / clenching	☐ Snoring / sleeping problems

If yes to any of the above, please elaborate: _____

Are there any other medical conditions that you may have? _____

Please list all medications you are currently taking: _____

For women only: Are you pregnant? _____If yes, how many weeks? _____ Are you nursing? _____

- Please tick if you are aware of the possibility that you may have the following high risk conditions:

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

If yes to any of the above, please elaborate: _____

I have answered all questions to the best of my knowledge. Should further information be required, the practice has my permission to request them from the respective health care provider. I understand that the information I have provided is important for the delivery of my dental treatment in a safe manner within this practice. I understand that this document will be treated in the strictest confidence by the practice. Our complete Privacy Policy is available at reception

Signature: _____ Date:_____