DIGGERS REST
DENTAL PRACTICE
2 Farm Rd, Diggers Rest, VIC 3427
T: 03 9012 7301 F: 03 9005 1067
www.diggersrest-dental.com.au

Patient Registration Form

Personal Details:

Title:	**Mr Mrs Ms Miss Mstr**	**Gender:**	**M F (Please circle)**
First Name:		**Date of Birth:**	**/ /**
Last Name:		**Country of Birth:**	
Address:			
Home No:		**Work No:**	
Mobile No:		**Occupation**	
Email:			
Parent 1 Details	**Name:**	**Number:**	**(For children only)**
Parent 2 Details	**Name:**	**Number:**	**(For children only)**

Aboriginal & Torres Strait Islander: (Please tick)

No ( )	Aboriginal ( )	Torres Strait ( )	Both ( )

Medicare, DVA and Private Health:

Medicare Card No:		Expiry Date:	/ / 20
DVA Card Number		Expiry Date:	/ / 20
Private Health Fund:		Member Number:	

Emergency Contact:

Contact Name 1:		Contact Number 1:	
Contact Name 2:		Contact Number 2:	

Would you like to receive a reminder for your appointment? Yes ( ) No ( ) SMS ( ) Email ( )
Is this consultation related to Workcover or Work-related Injury? Yes ( ) N ( )

Please read carefully and answer the following questions about your health and tick the relevant answer:

Do you currently have or have you ever had any of the following:

1. Surgical operation under General Anaesthesia? ( ) Reaction to General Anaesthesia? ( )
2. Anxiety/Depression? ( ) Medicated ( ) Non medicated ( )
3. Arthritis? ( )
4. Asthma? ( ) Mild ( ) Moderate ( ) Severe ( )
5. Other Respiratory Disease? ( )
6. Back or Neck Problems? ( )
7. Cancer? ( )
8. Diabetes? ( ) - Controlled by: Diet ( ) Medication ( ) Insulin ( )
9. Heartburn, Acid Reflux or other Digestive System Problem? ( )
10. Heart Condition or Surgery? ( ) – Pacemaker? ( )

11. High Blood Pressure ( )
12. HIV ( ) – Hepatitis B ( ) or C ( )
13. Infectious Disease? ( )
14. Kidney Disease? ( )
15. Nervous System Condition? ( ) – Sensory Problems? ( )
16. Osteoporosis? ( ) – On Medication ( ) When did you stop this medication?
17. Thyroid Disease? ( )
18. Autism? ( ) ADHD? ( ) Learning Delay? ( ) Speech Delay? ( )
19. Are you pregnant? Yes ( ) No ( ) N/A ( )
20. Stroke? ( )
21. Do you smoke? ( ) How many cigarettes a day? ( )
22. Alcohol? ( ) Heavy ( ) Not heavy ( )
23. Illicit Drugs? ( ) – Are you on Methadone Program? ( )
24. Are you on any other regular medications? Yes ( ) No ( ) List including over the counter:
    . . . . . .
    Blood thinners ( ) Bisphosphonate ( ) Steroids ( ) Immunosuppressive ( ) Cholesterol ( )
25. Do you have any allergies?( ) - Antibiotics ( ) Other Medications ( ) Food ( ) Substance ( )
26. Have you ever had any complications after dental treatment? ( )
27. Any dental fear or phobia? ( )
28. Any other conditions? ( )

Consent:

1.	I give consent for medical information to be obtained by my dentist for the purpose of my dental treatment and passed on to a third party for further treatment if required.	Yes	No
2.	I give consent to release my results to my designated relative/carer. Relative Name: Contact No:	Yes	No
3.	I give consent for my contact details to be obtained for the purpose of contacting me regarding medical matters or appointments.	Yes	No

Medical practitioners at Diggers Rest Medical Centre are committed to providing our patients with the best care. To do this it is essential that your health records are kept up to date and accurate. We recognise the importance of privacy and confidentiality for all our patients.

Acknowledgement:

I, ... acknowledge that all the information provided in this form is true and correct. I also agree to be responsible for all payments and will pay the amount due at their due time.

Signature: . . . . . Date signed: / / 20

Name of the person responsible for the fees: . . . . . .

Address:

Contact Phone Number:

Office Use Only:

Form Complete? ( ) Data entered in system? ( )

Signature: Name: Date: / / 20