

# NEW PATIENT REGISTRATION/ MEDICAL HISTORY FORM



## PERSONAL DETAILS

Title \_\_\_\_\_ First Name \_\_\_\_\_ Surname \_\_\_\_\_ Preferred name \_\_\_\_\_

DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Suburb \_\_\_\_\_ Postcode \_\_\_\_\_

Medicare Number \_\_\_\_\_ Patient ref no \_\_\_\_\_

Do you have Private Health Insurance?  Yes  No  
Name of Fund \_\_\_\_\_ Membership Number \_\_\_\_\_ Patient ref no \_\_\_\_\_

Emergency contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about us?  
 Google  Walked past  Social Media  Referred by \_\_\_\_\_  Other \_\_\_\_\_

## MEDICAL HISTORY

Medical doctor (GP) \_\_\_\_\_

Do you suffer or have you ever had any of the following medical conditions or treatments:

- |                   |  |                    |  |
|-------------------|--|--------------------|--|
| Anaemia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Valve        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood transfusion  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis B/C     | <input type="checkbox"/> Yes <input type="checkbox"/> No | H/L blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Panic attacks      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Steroid therapy   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis      | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/ AIDS          | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## MEDICAL HISTORY (continued)

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Other medical conditions (please specify)

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What medication/s are you currently taking? (please specify)

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Do you have any allergies? (eg. latex, dairy, sulphur drugs, Penicillin, Erythromycin)

Yes  No (please specify)

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If female, are you pregnant?

Yes  No

Do you smoke?

Yes  No

## DENTAL HISTORY

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Do you experience any of the following dental problems?

- Bleeding gums     Bad breath     Tooth discolouration     Clenching jaw  
 Painful /sore gums     Sensitive to hot/cold     Swollen gums     Grinding teeth

Other (please specify)

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## DECLARATION & CONSENT

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In signing this form, I acknowledge that I have filled out this form to the best of my knowledge and ability, as honestly and accurately as possible.

- I understand the need to advise my dentist of any changes to my medical history in future
- I have read and understood Greville Rd Medical & Dental's Privacy Policy
- I acknowledge that the practice requires a minimum of 24 hours notice if I need to cancel an appointment, otherwise a \$50 cancellation fee applies
- I am aware that full payment is required on the day of treatment. Greville Rd Medical & Dental accepts cash, Eftpos, Mastercard, Visa & Amex.
- I understand and agree that in the event of my account remaining unpaid and being referred to a debt collection agency and/or law firm, all collection and legal demand costs will be added to my account for which I am responsible for.

I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated. I will assume full responsibility for the fees associated with those procedures. I understand diagnostic tools such as radiographs, photographs and study models may be required prior to the commencement of certain dental procedures.

Patient/Guardian (if patient is under 18 years old)

Date:

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