Corio Dental Surgery
ABN 50 006 680 486

112 Bacchus Marsh Rd CORIO, Victoria, 3214
Telephone (03) 52 753444
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PATIENT REGISTRATION FORM

Title _____ **First Name** _____ **Surname** _____
Date of Birth _____ **Phone number** _____
Address _____
_____ **Post Code** _____
Email _____
Would you like a text message to your mobile reminding you of your appointment **YES** **NO**

If under 18, parent / guardian name _____
Are there other immediate family members who attend this clinic? If so, who?
_____

Emergency contact Name _____ **Phone** _____
Relationship to you _____

Do you have Private Health Insurance? YES NO Fund name _____

MEDICAL HISTORY + MEDICATIONS

To the best of your knowledge, do you have, or have you suffered from the following? Please list any **medications** you take for these conditions.

- ☐ High blood pressure _____
- ☐ Stroke _____
- ☐ Cardiac/heart disease _____
- ☐ Rheumatic Fever _____
- ☐ High cholesterol _____
- ☐ Arthritis _____
- ☐ Respiratory / Lung disease _____
- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Thyroid problems _____
- ☐ Osteoporosis _____
- ☐ Cancer _____
- ☐ Anxiety _____
- ☐ Mental health _____
- ☐ Bowel /Digestive Problems (reflux) _____
- ☐ Kidney problems _____
- ☐ Liver problems _____
- ☐ Bleeding disorders _____
- ☐ Sleep apnoea _____
- ☐ Infectious diseases (MRSA, VRE, STD, HIV, AIDs) _____

Do you smoke? YES NO If so, how many per day? _____
Do you drink alcohol? DAILY WEEKLY MONTHLY
Do you think you may be pregnant? If so, how many weeks? _____

There are a number of medications that may impact on your oral health or the treatment we plan and provide for you. Are there <u>any other medications</u> not listed above that you take?
(Blood thinners, hormone replacement, contraceptive pill, cancer medications, antibiotics, pain killers – eg panadol or nurofen, natural therapies)
_____
_____
_____

Do you have any allergies? Please list _____

I have completed this form to the best of my knowledge and understand that failure to fully disclose any conditions or medications places me at undue medical risk.
Privacy: *your information is kept confidential. You are entitled to access your information at any time. Any notes, radiographs or models relating to your treatment may be sent to other dental or medical practitioners to aid in your treatment. Our complete privacy policy is available at reception.*
Terms of Payment*: I accept responsibility for my account and understand that the fee is payable on day of treatment. Failure to settle the account on the day may be referred to a debt collection agency; I may be held liable for the costs of such collection plus interest. I accept full responsibility for health fund claims and rejections. Any fees incurred by the practice for cheques not accepted may be passed on to me.*

Signed _____ **Date** _____