Patient Registration Form

Welcome to The Point Dental. Please answer all questions.
All information is strictly confidential.

Title: _____ **First Name:** _____ **Middle Initial:** _____ **Family Name:** _____

Address: _____

_____ **Post Code:** _____

Date of birth: _____ **Home Phone No:** _____

Mobile No: _____ **Work No:** _____

Email address: _____

Occupation: _____ **Business Name:** _____

Emergency Contact: _____ **Phone No:** _____

Person responsible for payment: _____

Who is your current or previous dentist? _____

Who is your medical doctor? _____ **Phone No:** _____

Do you have Dental Insurance? Yes No Which Health Fund? _____ **Patient Line No:** _____

How did you hear about our practice? (Please circle)

Signage Website Google Facebook Word of mouth Radio Newspaper

Recommended by a patient of this practice (Name _____)

Others (Please elaborate _____)

TERMS: STRICTLY PAYMENT ON THE DAY, PLEASE. WE ACCEPT HICAPS, CASH, EFTPOS AND CREDIT.

"I acknowledge that the personal information collected from me by The Point Dental is collected for the purpose of allowing The Point Dental to provide services to me, and that if I do not provide relevant information, The Point Dental may be unable to provide those services. I acknowledge that my information may be disclosed in part or full in accordance with statutory requirements, including disclosure to government and health organisations. I acknowledge that I am aware that I have rights to access my personal information held by The Point Dental in accordance with the National Privacy Principles".

DENTAL FEES

Our practice is committed to providing you with the best treatments and we charge what is usual and customary for the service. You will be informed of fees before your treatment begins. It is your responsibility to discuss any financial concerns you have before your treatment is commenced.

DEPOSITS POLICY

The Point Dental reserves the right to charge deposits at the time of booking treatment. A non-refundable cancellation fee for any appointment that is cancelled with less than 24 hours' notice or patients fails to show. We understand that situations may arise that would make it impossible to give 24 hours' notice so each instance will be given consideration based on its merits.

Thank you for understanding our outlined policies above. Please let us know of any questions of concerns.

SIGNED: _____ **DATE:** _____

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Medical History

The state of your health may have a very significant effect on your dental care and is essential in appropriate treatment planning. Please answer all questions. Please tick the appropriate boxes, and give details when necessary.

***I have private and confidential medical matters that I wish to discuss with the dentist** □ Yes □ N

Do you have or ever had any of the following conditions? (Please tick if yes)

☐ Heart disease	☐ Stroke	☐ Psychological disorder	☐ Arthritis
☐ High blood pressure	☐ Head and neck injuries	☐ Depression	☐ Osteoporosis
☐ Low blood pressure	☐ Bleeding disorder	☐ Neurological disorder	☐ Prosthetic Knee
☐ High Cholesterol	☐ Bruise or bleed easily	☐ Epilepsy / seizures	☐ Prosthetic Hip
☐ Cardiac Pacemaker	☐ Kidney disorder	☐ Digestive disorder	☐ Faint easily
☐ Cardiac Stent	☐ Hormone deficiency	☐ Bulimia Nervosa	☐ Cold sores
☐ Chest pain	☐ Thyroid disease	☐ Gastric Reflux	☐ Tumour/Cancer
☐ Heart attack	☐ Autoimmune disease	☐ Stomach ulcers	☐ Lumps in mouth
☐ Congenital heart defects	☐ Diabetes (Type 1)	☐ Liver disorder	☐ Leukaemia
☐ Infective endocarditis	☐ Diabetes (Type 2)	☐ Hepatitis B	☐ Radiotherapy
☐ Rheumatic Fever	☐ Asthma	☐ Hepatitis C	☐ Chemotherapy
☐ Artificial heart valve	☐ Tuberculosis	☐ Creutzfeldt-Jakob Disease	☐ AIDS/HIV
☐ Breathing or sleep problem (i.e. Sleep Apnoea, snoring, sinus)		☐ Frequently experiencing headaches	

If yes to any of the above, or if you have any other medical conditions, please give details: _____

_____

Do you have any of the following allergies? (Please tick if yes)

☐ Penicillin	☐ Tetracycline	☐ Cephalosporin's	☐ Erythromycin	☐ Latex
☐ Valium	☐ Morphine	☐ Codeine	☐ Aspirin	☐ Hay fever
☐ Sulphur	☐ Chlorine	☐ Local Anaesthetic	☐ Metal (e.g. nickel, gold, silver)	

☐ Other (please list)_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often and how many? _____

Do you smoke? ☐ Yes ☐ No If yes, for how long? _____ How many per day? _____

Please list any medications or drugs you are taking: _____

_____

Females:

Are you pregnant? ☐ Yes ☐ No Due date: _____

Are you taking birth control pills? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

SIGNED: _____ **DATE:** _____

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Dental History

When was your last dental check-up? _____

What is the purpose of your visit today? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
34. Have you ever whitened (bleached) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

In signing this form, I acknowledge that this represents an accurate medical and dental history.
I will advise my dentist of any changes in the future.

SIGNED: _____ **DATE:** _____