PATIENT REGISTRATION

Surname: _____ First Name: _____ Title: _____

Date of Birth: _____ Gender: Male / Female

Home Address: _____

Business Address: _____

Email Address: _____ Home Phone No: _____

Work Phone No: _____ Mobile Phone No: _____

Fax No: _____ Occupation: _____

Is another member of your Family a Patient at our Office? Yes / No

Name: _____ Relationship: _____

Who were you referred by?: _____

Name of Parent / Guardian: _____

Do you have insurance for dental cover? Yes / No Surgical Cover? Yes / No

Person to Contact in Case of Emergency: _____ Phone: _____

Address: _____

1. Are you receiving any medical treatment at the preset time? Yes / No
2. Have you ever been in hospital recently, or for anything serious? Yes / No
3. Have you ever had any of the following? (only tick a box if it relates to you)

☐ Rheumatic Fever	☐ Epilepsy	☐ Heart Trouble/Murmur
☐ Anemia	☐ High Blood Pressure	☐ Diabetes
☐ Asthma	☐ Low Blood Pressure	☐ Arthritis
☐ Gastric Problems	☐ Bone diseases	☐ Cold Sores
☐ Bronchitis or Chest Problems	☐ Depressive Illness	☐ Severe Headaches

☐ Drug dependence or the recreational use of prescription or non prescription drugs

4. Are you taking any tablets, capsules, medicines or drugs Yes / No
   If yes, please list:_____
   _____
5. Have you any allergies to medicines that you are aware of? Yes / No
   If yes, please list: _____
6. Are you wearing an artificial or prosthetic joint? Yes / No
7. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
8. Have you ever had contact with HIV or Hepatitis B or C virus? Yes / No
9. Have you ever had a reaction to anaesthetic? Yes / No
10. Women: Are you pregnant now, or are you possibly pregnant? Yes / No
11. Do you have or have you had any diseases, conditions or problems that are not listed? Yes / No
12. Any other aspects concerning you health or behaviour that we should know about? Yes / No

What is the reason for your visit today? _____

Date of last Dental Visit: _____ Last dental cleaning: _____ Last full mouth X-rays: _____

What was done at your last dental visit? _____

Name & address of previous dentist? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other aids do you use? (Interplak, toothpick, etc?) _____

Do you have any dental problems now? Yes / No

If yes, please describe: _____

Have you ever had:

Orthodontic Treatment	Yes / No
Oral Surgery	Yes / No
Specialist gum treatment	Yes / No
A grinding splint	Yes / No
A serious injury to the mouth or head	Yes / No

Do you:

Clench or grind your teeth regularly	Yes / No
Have tired jaws, especially in the morning	Yes / No
Smoke/Chew tobacco	Yes / No

Are any of your teeth sensitive to:

Hot or Cold	Yes / No
Sweet	Yes / No
Biting or Chewing	Yes / No

Have you noticed:

Any mouth odours or bad tastes	Yes / No
Your gums bleed?	Yes / No

Have you experienced:

Clicking or popping in the jaw	Yes / No
Difficulty in opening or closing the mouth	Yes / No
Difficulty chewing on either side of the mouth	Yes / No

Are you satisfied with your teeth's appearance? Yes / No

Would you like to keep all of your teeth all of your life? Yes / No

Do you feel nervous about having dental treatment? Yes / No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes / No

Is there anything else about having dental treatment that you would like us to know? Yes / No

If yes, please describe: _____

Privacy: *I understand and confirm that this clinical record sheet collects personal and health information about me for the purpose of assessing my medical history prior to my treatment. I authorise Jervois Dental to collect information from my General Practitioner or specialist if clarification or further information is required for the purpose of assessing my medical condition. I understand that if I give false or misleading information it may affect the treatment provided. You have the right to assess and request correction of the information in accordance with the Privacy Act 1993 and Health Information code 1994.*

Signed by: _____ Date: _____