jervois dental
caring with excellence

NEW PATIENT REGISTRATION FORM

SECTION ONE YOUR DETAILS

First names _____ Last name _____

Title: Dr Mr Mrs Miss Ms Mast (circle) Date of birth _____

Home address _____

Mobile phone _____ Email _____

Home phone _____ Work phone _____

Preferred contact method: Home Work Mobile Text Email (circle)

How did you find out about Jervois Dental? **Ponsonby News** **Internet** **Yellow Pages** **Saw the sign** **School**

I was referred by (name) _____

Occupation _____ Employer _____

In case of an emergency, who can we contact? Name _____

Phone _____ Relationship to you _____

Doctor's name _____ Practice _____

If you are under 18: Parent's name _____ Parent's phone _____

SECTION TWO YOUR DENTAL HISTORY

1. What is the reason for your visit today? _____

2. When was your last dental visit? _____

3. Who was your previous dentist or hygienist? _____

4. What do you use to clean your teeth at home? _____

5. Are your teeth sensitive to:

Hot	YES	NO
Cold	YES	NO
Sweet	YES	NO
Biting/Chewing	YES	NO

6. Have you ever had:

Orthodontics (braces)	YES	NO
Gum treatment	YES	NO
An injury to your teeth or jaws	YES	NO
A bad dental experience	YES	NO

7. Have you ever been aware of:

Sore or bleeding gums	YES	NO
Clicking or popping of the jaw	YES	NO
Jaw joint pain	YES	NO
Grinding/clenching	YES	NO
Head/neck/facial ache or pain	YES	NO

8. I prefer dental treatment with Local Anesthetic only YES NO

I would like to have Intravenous Sedation YES NO

SECTION THREE YOUR MEDICAL HISTORY

1. Are you currently taking any medications? YES NO

If yes, which medicines? _____

2. Are you aware of any allergies or adverse reactions that you have? YES NO

If yes, details _____

3. Have you ever had, or been treated for, any of these conditions?

Heart trouble	YES	NO	Stroke	YES	NO
High blood pressure	YES	NO	Artificial/Prosthetic joint	YES	NO
Blood disorders	YES	NO	Allergy	YES	NO
Anaemia	YES	NO	Diabetes	YES	NO
Rheumatic fever	YES	NO	Hepatitis	YES	NO
Asthma	YES	NO	Arthritis	YES	NO
Gastric reflux	YES	NO	Epilepsy	YES	NO
Low blood pressure	YES	NO	Fainting or dizziness	YES	NO
Latex sensitivity	YES	NO			

4. Have you ever had, or are you being treated for, any diseases or problems not listed? YES NO

If yes, details _____

5. Any other aspects concerning your health or behaviour that we should know about? YES NO

If yes, details _____

6. Do you believe yourself to be at risk from the HIV and/or Hepatitis virus? YES NO

7. Do you smoke? YES NO **If yes,** amount per day _____

8. Do you take any self-prescribed and/or recreational drugs? YES NO

If yes, details _____

9. Women: Are you pregnant? YES NO **If yes,** number of months _____

SECTION FOUR OUR AGREEMENT

Our commitment to you: At all times, we will provide you with the very best dental care available. As a patient at Jervois Dental, your well-being is our first priority.

Your commitment: I agree that I am responsible for payment of all service on my behalf or on behalf of my dependents. I understand that payment is due at the time of treatment unless other arrangements have been finalised, and that a 1.5% fee will be added to outstanding accounts. If required for debt collection, I understand that a check of my credit history may be made, and/or my details may be passed to a third party. I understand that any costs incured for debt collection will be payable by me.

Cancellation policy: I understand that by making appointments with Jervois Dental, I am agreeing to attend the appointments or to give a minimum of 48 hours notice of cancellation of appointments. If I cancel within 48 hours or fail to attend an appointment, I understand that a charge of $50 per half hour of the scheduled appointment time will be charged.

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 the Health information code 1994.

Signed _____ **Date** _____ **Checked** _____