ABN: 88109898606
3/6-8 Langmore lane, Berwick-3806
03 97962029 contact@dentcare.com.au

Patient Registration Sheet

In order for this dental practice to provide the highest standard of care, it is requested that you fill in this form carefully and thoroughly

First name:…….. Date of Birth:……

Surname:…… Title:……..

Preferred name:……

Occupation:……

Gender:……

Home address:…… ……

P/code:……

Mobile:…… Alt. Ph…….. Email: ……

Emergency contact:…… Relationship:……

Ph:……..

How did you find out about A Better Dental Care?:……

Do you have dental insurance? Y/N – if yes, which fund?.....

Name of your physician: _____

Address: _____

Notice to insured patients regarding dental benefits insurance

Item numbers on our statement represent as accurately as possible the procedures performed, but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures, to attract refunds, and the rates of those refunds, are determined by the conditions of the patient's health insurance policy. We accept no responsibility, to either party, for any decision the insurer may make during the refund of monies to the patient

Patient Medical History Sheet

In order for this dental practice to provide the highest standard of care, it is requested that you fill in this form carefully and thoroughly

Conditions	✓	Any Details
High Blood Pressure		
Heart problems		
Rheumatic fever		
Artificial Joint / Heart Valve		
Blood Disorders / Thinners		
Allergies to medications/ latex		
Asthma		
Sinus trouble		
Epilepsy		
Diabetes		
Tumour History		
Radiation Treatment		
Hepatitis (A/ B/ C/ D /E)/ HIV		
Ulcers (stomach)		
Liver disease		
Kidney disease		

Medication

…… ……

…… ……

…… ……

Lifestyle

Smoke per day Y

Pregnant/possible Y If Yes Due date : ……

Warnings

Hearing/sight impairment Y

Antibiotic cover required Y

Do Not Recline Y

Anything dentist should know……..

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk.

On future visits, any changes to the above should be advised

Signed…… Date……

Dental history Sheet

In order for this dental practice to provide the highest standard of care, it is requested that you fill in this form

Purpose of today's visit _____

How long since your last dental appointment? _____

How often do you have dental examinations? _____

Any bad dental experience in the past?_____

Previous dental x-rays were taken: Less than a year ago/Longer than a year

	Yes/No
Do you think you have bad breath?	
Does your gums bleed?	
Do you have fillings frequently breaking off	
Do you have Missing Teeth?	
Do you have jaw joint problems	
Do you feel that you grind/clench your teeth in sleep	
Do you snore or have sleep apnoea?	
Any concern with the appearance of the teeth?	

Consent for treatment

I hereby authorise the dentist or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis.

Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anaesthetics', sedatives, and other medication, as necessary.

I fully understand that using anaesthetic agents embodies certain risks.

I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents.

I understand that payment is due at the time of service unless other arrangements have been made.

I authorise that this data may be reviewed by team members of the dental practice For clinical purpose.

Patient/ Guardians signature: _____ Date: _____

Name: _____ Relationship to patient: _____