PYMBLE Medical & Dental CENTRE

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FAMILY DENTAL REGISTRATION FORM

Dr Tuan Nguyen, Dr Anne Nguyen and their team welcome you to **Pymble Medical and Dental Centre**. We assure you a caring, gentle environment and our complete attention to make your visit as comfortable and relaxed as possible.

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. We respect your right to privacy and the information you provide will be treated with the utmost confidentiality. **Please fill both sides of this form.**

ADULT / PARENT DETAILS

Title: *Dr / Mr / Mrs / Miss / Ms/ Other* Surname _____

First name _____ Date of birth ____/____/ _____

Address _____

_____ Postcode _____

Phone no: Mobile _____ Home _____ Work _____

Email _____ Occupation _____

CHILDREN UNDER 16 DETAILS BELOW

Name	Surname	DOB	Position on health fund card	Any Medical conditions or allergies please provide details below	Position on Medicare card

Best confirmation Method for appointments (please circle): SMS TELEPHONE EMAIL

Health fund for dental cover _____Position on Card _____

Medicare number_____

Person to contact in case of emergency _____

Relationship to patient _____ Contact No. _____

How did you hear about us?

Website ☐ Walk-by/Drive- by ☐ Brochure in Letter Box ☐ Family/Friends ☐
Other ☐ _____

DENTAL HISTORY

What is the main purpose of your visit today? _____

Have other members of your family attended this practice previously? Y ☐ N ☐
When was your last dental treatment? _____

Are you concerned about or experiencing any of the following (Please tick those that apply)

- ○ Sensitivity
- ○ Stained/discoloured teeth
- ○ Bleeding gums
- ○ Bad Breath
- ○ Appearance of teeth
- ○ Discomfort in mouth
- ○ Grinding/Clenching of your teeth
- ○ Clicking/pain in the jaw joints

MEDICAL HISTORY- Private and Confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Name of GP _____ **Phone** _____

GP Practice Name _____

Are you undergoing any medical treatment at present Y ☐ N ☐

Do you normally require antibiotic cover before dental treatment? Y ☐ N ☐

Have you had any abnormal reactions to local or general anaesthesia? Y ☐ N ☐

Do you have any allergies (E.g. Medications, Latex, dairy, etc): _____

Are you taking any medication? (Prescription, over the counter, herbal) **especially blood thinners**

_____

Are you pregnant? (Females only) Y ☐ N ☐ If yes, how many months?_____

Past/Current medical conditions:

Please indicate below if you have had, or have at present any of the following: (please tick)

	Any heart complaint/treatment		Anxiety/Depression
	Rheumatic fever or Heart murmur		Thyroid disease
	High or low blood pressure		Kidney disease
	Excessive bleeding or Blood disorders		Hepatitis
	Joint replacement surgery		HIV/AIDS
	Bone disease- e.g. Osteoporosis		Radiation therapy/chemotherapy
	Epilepsy		Cancer
	Diabetes		Transplanted organ or bone marrow
	Asthma / Breathing problems		Prosthetic implant or pacemaker
	Steroid therapy		Other (please list):_____ _____

Please provide further details:

_____

_____

CONSENT FOR SERVICES

- I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and other medication as indicated.
- I understand that Pymble Medical and Dental Centre require payment on the day of treatment.
- We provide a courtesy to our patients of a preventive recall program that offers a reminder letter if you have not been to the practice in 6 months. (Please indicate here to opt out ☐)

CANCELLATION POLICY: To avoid being charged a cancellation fee of $50, we require at least 24 hours notice should you wish to cancel an appointment.

PLEASE NOTE: The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

X Signature _____ Date ____ / ____ / _____

Carer/guardians name_____ (if different to parent).