NEW CLIENT REGISTRATION FORM

First name: ___________________________Last name:___________________________________

Preferred name: _______________________Date of birth:_________________________________

Home address: ____

Suburb:________________________Postcode:____________________________________

Phone (home): ________________________Phone (work/mobile):__________________________

Email: ____

Name of person responsible for fees:____

School attended or Occupation:____

Do you have dental insurance? ☐ No ☐ Yes Which fund?_________________________________

How did you hear about us? ☐ Friend/family. Who may we thank for referring you? _______

☐ Referred by dentist ☐ Walked/drove past

☐ Google search ☐ Other ______________________

Please complete the following if patient is under 18 years of age:

Parent names:____

Parents address (if different from child): ____

Suburb:________________________Postcode:_________ Phone: ____________________

YOUR DENTAL HEALTH

Name of general dentist: ____

Dentist address: ____

When was your last dental check-up? ____

What is your main concern with your teeth?____

Is there any history of injuries to your face, mouth or teeth? .... ☐ Yes ☐ No

Have you had previous orthodontic treatment?... ☐ Yes ☐ No

Has anyone in your family had orthodontic treatment? .... ☐ Yes ☐ No

Have you ever sucked your thumb or fingers? If yes, until what age? .... ☐ Yes ☐ No

Have you ever had any problems with dental treatment in the past?........................... ☐ Yes ☐ No

If YES, please describe ____

[Please TURN OVER and complete the medical questionnaire]

YOUR HEALTH

What is your family doctors name? ____
Address: ____
Phone: ____

Have you ever had any of the following?
Asthma/breathing problems.. ☐Yes ☐No
High blood pressure .... ☐Yes ☐No
Heart problems .... ☐Yes ☐No
Rheumatic fever... ☐Yes ☐No
Autism spectrum disorder .... ☐Yes ☐No
Diabetes .... ☐Yes ☐No
Epilepsy .... ☐Yes ☐No
Excessive bleeding or blood disorder .... ☐Yes ☐No
Tuberculosis .... ☐Yes ☐No
Kidney/liver problems.. ☐Yes ☐No
Thyroid problems... ☐Yes ☐No
Arthritis or joint problems .... ☐Yes ☐No
Hepatitis... ☐Yes ☐No
HIV/AIDS.. ☐Yes ☐No
Mental health issues .... ☐Yes ☐No
Please list any other illness not mentioned ____

Are you currently taking any medicines or tablets? .... ☐Yes ☐No
If YES, please give details ____

Have you ever stayed in hospital or had a general anaesthetic? .... ☐Yes ☐No
If YES, please give details ____

Do you have any prosthetic implants including artificial joints and heart valves?.......... ☐Yes ☐No

Are you allergic to any products or medicines?.. ☐Yes ☐No

Are you allergic to latex? .... ☐Yes ☐No

Females, are you pregnant? .... ☐Yes ☐No

Do you smoke? ☐ Yes ☐ No How many per day?........... Would you like to stop? ☐Yes ☐No

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may put me at undue medical risk. I understand that at times my dental records (notes, x-rays, photographs, models) may need to be sent to other dental practitioners to aid in my treatment, and I consent to this.

Signed:____

Please print name: ____

Relationship to patient (if not self): ______________________________________

Date: ____