WODEN DENTAL CARE

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Woden, ACT 2606
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Registration Form

Surname: _____ Given Names: _____Preferred Name: _____
D.O.B: _____ Occupation: _____
Address:_____ Postcode: _____
Email: _____
Phone No: (H)_____ (W) _____ (M) _____
Family Doctor (GP):_____Phone No:_____
Address: _____

Please answer all of the following questions.	**Yes**	**No**
• Are you currently receiving medical attention?	☐	☐
• Are you currently taking any medication?	☐	☐
Details: _____		
• Do you smoke?	☐	☐
• Women: Are you pregnant?	☐	☐
• Do you have any known allergies?	☐	☐
Details: _____		
• Have you ever had or suffered from any of the following medical conditions?		
○ Rheumatic fever	☐	☐
○ Heart disorder(heart murmur), chest pain	☐	☐
○ Blood pressure	☐	☐
○ Pacemaker/Cardiac surgery	☐	☐
○ Epilepsy	☐	☐
○ Stomach ulcer/Hiatus hernia	☐	☐
○ Asthma	☐	☐
○ Bronchitis	☐	☐
○ Diabetes	☐	☐
○ Radiotherapy/Chemotherapy	☐	☐
○ Organ transplant	☐	☐
○ History of prolonged bleeding/blood disorder	☐	☐
○ Blood or other transfusions	☐	☐
○ Hepatitis (A, B, C, D), AIDS, or HIV	☐	☐
○ AIDS or HIV	☐	☐
○ Other: _____		

When was your last dental visit?_____
What treatment was provided?_____
What is the purpose of your visit today? Please circle your answer.
Check-up/Toothache/Bleeding gum/Broken tooth/Improving smile/others_____
Who is responsible for your fees? _____
Health Fund Details: _____

PLEASE NOTE: FULL PAYMENT IS REQUIRED ON THE DAY OF SERVICE. PLEASE DISCUSS WITH OUR STAFF IF THIS SHOULD POSE ANY DIFFICULTIES.

Patient signature (Parent/Guardian if the patient is under 16) _____
Date:_____/____/_____