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"Castlegate Family Dental"

CASTLEGATE

FAMILY DENTAL CARE

Dental Practice ACCREDITED

Patient Registration and Medical Questionnaire

PRIVATE AND CONFIDENTIAL

Welcome to Castlegate Family Dental Care

Please answer all questions as completely as possible, it will greatly assist us to provide the best dental treatment for you.

Name (Mr/Mrs/Miss/Master/Ms/Dr/Other) ..... (First Names) ..... (Family Name)

Address .....

..... Postcode .....

Date of Birth ..... Phone (Home) ..... Phone (Work) .....

Phone (Mobile) ..... Preferred Daytime Contact: Home/ Work/ Mobile *(Please Circle)*

E-mail .....

Occupation ..... Employer .....

Emergency Contact ..... Relationship ..... Phone .....

Person responsible for accounts .....

Medicare number ..... I.D. .....

Do you have Private Health Insurance? If Yes which one? .....

Member Number ..... ☐ Hospital cover ☐ Ancillary cover (i.e dental, physio, optical)

Whom may we thank for recommending you to our practice? .....

The state of your health may have a very significant effect on your dental care.
Please answer these questions fully or discuss them with your dentist:

	Y	N
• I have private and confidential medical matters which I wish to discuss with the dentist	☐	☐
• Are you receiving any medical treatment at present?	☐	☐
• Name of your GP/ specialist		
• Have you ever been in hospital? If yes, nature of hospitalisation and dates:	☐	☐

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- Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.

Please list any medications you are currently taking, or have been recently taking *(including* herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants), so we can take appropriate precautions and avoid drug interactions.

Drug Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. penicillin) medicines, antiseptics, local anaesthetics or preservatives that we should know about.

Drug Name	Nature of Reaction	How Long Ago

Please indicate YES or NO if you have ever had any of the following:

	Y	N		Y	N
Rheumatic fever	☐	☐	Thyroid (including goitre)	☐	☐
Heart condition/ cardiac surgery/ pacemaker	☐	☐	Tuberculosis (TB)	☐	☐
Heart valve replacement	☐	☐	Asthma/ Bronchitis/ Lung conditions	☐	☐
High or low blood pressure	☐	☐	Nervous system disorder	☐	☐
Blood disorders	☐	☐	Anxiety/ Depression	☐	☐
Excessive bruising or bleeding	☐	☐	Gastroesophageal reflux disease (GORD)	☐	☐
Hepatitis, HIV, jaundice or liver disease	☐	☐	Treatment for cancer (type/ region)	☐	☐
Kidney/ renal disease	☐	☐	.....		
Diabetes or family history of diabetes	☐	☐	Chemotherapy/ Radiation therapy	☐	☐
Osteoporosis or low bone density	☐	☐	Allergy to any foods, chemical or substance	☐	☐
Rheumatoid arthritis/ Lupus (SLE)/ Polymyalgia	☐	☐	(eg. latex/ elastoplast)		
Joint replacement surgery	☐	☐	Transplanted organ/ bone marrow/ stem cells	☐	☐
Jaw, neck or shoulder injury or pain	☐	☐	Snoring/ Sleep Apnoea	☐	☐
Epilepsy/ Seizures	☐	☐	Autism	☐	☐

Have you ever smoked? Y ☐ N ☐ Approx. date if quit ...../...../..... Do you currently smoke? Y ☐ N ☐

If yes, for how long?..... How much do you smoke..... per day

Have you ever used illicit substances and/ or recreational drugs? Y ☐ N ☐

If yes, when? Recent ☐ More than 1 yr ago ☐

Have you ever required any treatment for smoking related diseases or conditions? Y ☐ N ☐

Do you suffer from any illness not listed above or carry any infectious disease? Y ☐ N ☐

If yes, please provide details .....

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FEMALES: Are you pregnant or is there a chance you could be pregnant? Y ☐ N ☐ If yes, due date.....

Are you currently breastfeeding? Y ☐ N ☐

DECLARATION:

In signing this form I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient Signature..... Date .....
(Parent or guardian if under 18 years)

Dentist Signature..... Date .....

<u>Castlegate Family Dental Care Privacy Policy:</u> *We collect the information set out above in order to provide you with dental services. We will keep all your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.*

1. Accounts are to be paid in full on the day of service. We accept cash, personal cheques, Eftpos cards, Visa and MasterCard.
2. Overdue balances and collection fees. Should we engage the services of a debt collection agency you agree to pay all debt collection costs, including any interest charged and reasonable collection fees incurred in attempting to collect any overdue amounts.