Patient Registration

Date: ____________________

Surname: ____________________ First Name: ____________________ Title: ____________

Date of Birth: ____________________ Gender: M F

Home address: ____

Business address: ____

Email address: ____

Work Phone No: ____________________ Home Phone No: ____________________

Mobile Phone No: ____________________ Occupation: ____________________

Health Fund: ____

Is another member of your family a Patient at our Office? Yes No

Name: ____________________ Relationship: ____________________

Who were you referred by: ____

Name of Parent/Guardian: ____

Person to contact in case of emergency: ____________________ Phone: ____________________

Address: ____

Closest Relative not living with you: ____________________ Phone: ____________________

Address: ____

Person responsible for account: ____________________ Phone: ____________________

Address: ____

Relationship to patient: ____

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Tranquil Dental
"The Beauty of Healthy Teeth"

Dental History

Patient Name: ______________________ DOB: ____________

Welcome! So that we may provide you with the best possible care, please complete BOTH SIDES of this Medical/Dental History Form. All information is completely confidential.

What is the reason for your visit today? ______________________

Do you have any dental problems now? Yes No
If yes, please desribe: ______________________

Previous dentist's name ______________________

Address ______________________ State ____________ Postcode ____________

Telephone: ______________________

Date of last dental visit: ____________ Last dental cleaning: ____________ Last full mouth X-Rays: ____________
What was done at your last dental visit? ______________________

How often do you have a dental examination? ______________________

How often do you brush your teeth? ____________ How often do you floss? ____________
What other aids do you use?(Interplak, toothpik etc)? ______________________

Are any of your teeth sensitive to:

Hot or Cold?	Yes / No
Sweets?	Yes / No
Biting or Chewing?	Yes / No
Have you noticed any mouth odours or bad taste?	Yes / No
Do you frequently get sores, blisters or any other oral lesions?	Yes / No

Do your gums bleed or hurt:

Have you noticed any loose teeth or change in your bite?	Yes / No
Does food tend to become caught between your teeth?	Yes / No

If yes, where?

Do you:

Clench or grind your teeth while awake or asleep?	Yes / No
Bite your lips or cheeks regularly?	Yes / No
Hold foreign objects in your teeth? (pencils, pipe, pins, nails, fingernails)	Yes / No
Breathe through your mouth while awake or asleep?	Yes / No
Have tired jaws, especially in the morning?	Yes / No
Have sleep apnoea?	Yes / No

Have you ever had:

Orthodontic Treatment?	Yes / No
Oral Surgery?	Yes / No
Periodontal Treatment?	Yes / No
Your teeth ground or the bite adjusted?	Yes / No
A bite plate or mouthguard?	Yes / No
A serious injury to the mouth or head?	Yes / No
Any previous problems with dental infections?	Yes / No

If so, please describe, including cause?

Have you experienced:

Clicking or popping of the jaw?	Yes / No
Pain (joint, ear, side of face)?	Yes / No
Difficulty in opening or closing the mouth?	Yes / No
Difficulty in chewing or closing the mouth?	Yes / No
Headaches, neck aches, or shoulder aches?	Yes / No
Sore muscles (neck, shoulders)?	Yes / No

Is there anything else about having dental treatment that you would like us to know? ______________________

Have you ever had an upsetting dental experience? Yes/No
If yoes, please describe. ______________________

Do you feel nervous about dental treatment Yes/No
If yes, what is your biggest concern? ______________________

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Medical History

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Patient Name: ______________________ DOB: ______________

Have you been under the care of a medical doctor during the past two years? Yes / No

If yes, for what? ______________________

Physician's Name ______________________ Phone ______________

Address ______________________ State ________ Postcode ________

Have you taken any medication or drugs during the past two years? Yes / No

Are you taking any medication, drugs or pills now? Yes / No

If yes, please list name and dosage: ______________________

Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes / No

If yes, please list ______________________

Have you been a patient in the hospital during the past five years? Yes / No

Indicate which of the following you have had, or have at present. Circle 'yes' or 'no' to each item.

Heart (surgery, disease, attack)	Yes / No	Liver Disease	Yes / No	Diabetes	Yes / No
Chest Pain (angina)	Yes / No	Hepatitis	Yes / No	Ulcers	Yes / No
Congenital Heart Disease	Yes / No	Yellow Jaundice	Yes / No	Tumors	Yes / No
Heart Murmur	Yes / No	Haemophillia	Yes / No	Radiation Therapy	Yes / No
High Blood Pressure	Yes / No	Blood Transfusion	Yes / No	Chemotherapy	Yes / No
Artificial Heart Valve	Yes / No	Bruise Easily	Yes / No	Thyroid Problems	Yes / No
Heart Pacemaker	Yes / No	A.I.D.S/HIV Positive	Yes / No	Kidney Trouble	Yes / No
Rheumatic Fever	Yes / No	Deep Vein Thrombosis	Yes / No	Arthritis/Rheumatism	Yes / No
Artificial Joints (Hip etc)	Yes / No	Aenema	Yes / No	Psychiatric/Psychological Care	Yes / No
Asthma	Yes / No	Latex Sensitivity	Yes / No	Nervous Anxious	Yes / No
Lung Disease	Yes / No				
Emphysema	Yes / No				
Chronic Cough	Yes / No				

Have you lost or gained more than 5 kilograms (10 pounds) in the past year? Yes / No

Do you or have you ever smoked? Yes / No

if yes, When did you quit smoking? ______________________

How many cigarettes per day do you smoke? ______________________

Do you have or have you had any disease, condition or problem not listed? Yes / No

If yes, please list ______________________

Women - are you: Pregnant? Yes: Months No

Nursing Yes / No

Taking birth control pills? Yes / No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature ______________________ Date ______________

Dentists Signature ______________________

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Consent for Treatment

1. I hereby authorise doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient name) ______________________ 's dental needs.

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

3. I agree to the use of anesthetics, sedative and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made prior to treatment.

Patient's signature: ______________________ Date: ______________________

Parent/Responsible Party's Signature: ______________ Relationship to Patient: ______________________

Updated History

Date: ______________________ Signature: ______________________

Adjustments: ______________________

Date: ______________________ Signature: ______________________

Adjustments: ______________________

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