REGISTRATION FORM

FOCUS THIRTY TWO DENTAL

Today's Date:

FIRST NAME:	**MIDDLE NAME:**	**LAST NAME:**
Title:		Birth Date:

Address:

Email Address:	Home Phone Number:	Mobile Phone Number:
Occupation:	Employer:	Work Phone Number:

Referred by:

Other Family members seen here (other patients):

MEDICAL HISTORY

- Yes No Have you been treated in hospital during the past two years?
- Yes No When you graze or cut yourself, do you have excessive bleeding?
- Yes No Are you concerned about using local anaesthetic for routine dental treatments?
- Yes No Are you being treated by a doctor at present?
- Yes No Are you a smoker?
- Yes No Do you have any allergies? Please specify:
- Yes No Are you taking any medicine, tablets or drugs? If so, please list

Reason for your dental visit today:

When was the last time you visited a dentist?

Have you now, or ever had, any of the following:

Knee or hip replacement	Rheumatic Fever	Hepatitis	Asthma
Women – are you pregnant?	High Blood Pressure	Diabetes	HIV Positive
Kidney Disease	Heart Trouble	Epilepsy	Severe Headaches

Are there any other aspects concerning your health you think your Dentist should know about? If so, please note

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):

Relationship to patient:	Phone number:

FINANCIAL

Payment in full on the day of treatment is required unless a prior arrangement has been made. In complicated cases with multiple appointments, part payment is required as the treatment progresses. Unpaid or overdue accounts will incur a 10% interest penalty and collection costs will be the patient's responsibility. We accept Eftpos, Visa, MasterCard, QCard, Farmers Finance, Cash and Cheque methods of payment. Please note that all estimates of fees are based upon conditions viewed at the time of diagnosis, unforeseen circumstances can alter an estimated fee.

CANCELLATIONS

We understand that sometime it is necessary to change your schedule. Out of consideration for others we kindly ask you to provide a minimum of 24 hours' notice if you wish to change or cancel an appointment.

Signed	Date:

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment.

Patient / Guardian signature	Date: