REGISTRATION FORM

Patient/Parent/Guardian signature



FIRST NAME:		MIDDLE NAME:			LAST NAME:		
Title:		Birth Date:			Occupation:		
Email:					Employer:		
Mobile Number:		Home Number:			Work Number:		
Address:							
How did you hear about us?	Internet Search Fa		Fac	cebook			
Radio	Oriving/Walking By New		vspaper Other:				
MEDICAL HISTORY							
Have you had, or do you have any of the following:							
Asthma	Asthma Diabetes Exc			cessive bleeding/bruising Epilepsy			
Heart Trouble	High Blood Pressure He		Hep	oatitis HIV positive			
Knee/Hip Replacement	Kidney Disease R		Rhe	umatic Fever	tic Fever Severe Headaches		
Smoker	Cancer Pre		gnant: weeks				
Concerns About Local Anaesthetic Treated in Hospital during the past 2 years							
Do you have any allergies? Please specify:							
Are you taking any medicine, tablets or drugs? Please list:							
Are there any other aspects concerning your health that you think your dentist should know about?							
Doctor's Name: Medical Clinic:							
Emergency Contact Name:							
Relationship to patient:				Phone Number:			
DENTAL HISTORY							
Reason for your dental visit today:				When was your last dental visit? Did you have x-rays taken? Yes No			
Have you had, or do you have any of the following:							
Clicking/sore jaw	Food jammed between teeth			Bleeding gums when brushing/flossing OBad breath			
Chipped/broken teeth	Floss tearing between teeth			Fillings with a problem Cold/hot sensitivity			
Grinding your teeth	-			Bite your lips/cheek often Had your bite adjusted			
Wear a night guard Previous periodontal (gum) treatment Previous orthodontic treatment (braces)							
The above information is true to the best of my knowledge, and I have read and understood the Terms and Conditions on the reverse of this form. I understand and agree that I am financially responsible for payment.							

Date:

TERMS AND CONDITIONS

CONSENT FOR TREATMENT

I hereby authorize the dentist or designated team member to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives, and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of all my dependants. I understand that payment is due at the time of service unless other prior arrangements have been made. I authorize that this data may be reviewed by team members of the dental practice.

FINANCIAL

Full payment 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 sometimes 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.