DR PAUL B FITZ-WALTER
DR LUKE G MOLONEY
DR MATTHEW FILEI
DR ARTIKA SOMA

Camberwell Endodontics

PATIENT REGISTRATION FORM

WELCOME to our practice. For our records, and especially to assist us in providing the best treatment for you, please take the time to complete this form and answer the following questions as accurately as possible.

PLEASE PRINT CLEARLY

DO YOU REQUIRE ASSISTANCE TO COMPLETE THIS FORM? (please circle) NO YES

DO YOU REQUIRE AN INTERPRETER? (please circle) NO YES WHAT LANGUAGE DO YOU SPEAK? .....

TITLE: (please circle) Dr Mr Mrs Ms Master Miss Other: .....

LAST NAME: ..... GIVEN NAMES: .....

DATE OF BIRTH: ...../...../..... PREFERED NAME: .....

ADDRESS: .....

SUBURB: ..... STATE: ..... POSTCODE: .....

HOME PHONE: ..... WORK PHONE: ..... MOBILE: .....

POSTAL ADDRESS: (if different from above) .....

SUBURB: ..... STATE: ..... POSTCODE: .....

EMAIL ADDRESS: ..... OCCUPATION: .....

DO YOU HAVE *DENTAL* PRIVATE HEALTH INSURANCE? (please circle) NO YES *IF YES, **PLEASE PROVIDE DETAILS BELOW:**

PRIVATE HEALTH FUND NAME: ..... INDIVIDUAL MEMBER NUMBER (next to your name on card): .....

PLEASE INDICATE HOW YOU WOULD PREFER TO RECEIVE AN APPOINTMENT REMINDER: (please tick one box)
☐ Mobile Phone (Call) ☐ Home Phone (Call) ☐ SMS (Text)

DO YOU CONSENT TO US SENDING YOU AN *SMS REMINDER* FOR RECALL APPOINTMENTS? (please tick) ☐ YES ☐ NO – PLEASE POST A LETTER

IF YOU ARE UNDER 18 YEARS OF AGE - PLEASE STATE FATHER / MOTHER / GUARDIAN'S NAME: .....

IF RELEVANT, CARER NAME: ..... PHONE: .....

WHO IS RESPONSIBLE FOR THE ACCOUNT? .....

EMERGENCY CONTACT NAME: ..... PHONE: .....

GENERAL MEDICAL PRACTITIONER: .....DR..... PHONE: .....

WHO WERE YOU REFERRED BY? .....DR..... SUBURB: .....

If there was NO REFERRAL how did you hear about us? .....

Is your visit in connection with ANY of the following? (please circle) YES NO IF YES, PLEASE PROVIDE DETAILS BELOW:

WORKCARE: ..... TAC: ..... VETERAN AFFAIRS: .....

ARE YOU ABORIGINAL OR TORRES STRAIT ISLANDER; for health related issues? (please tick) ☐ YES ☐ NO ☐ DECLINE

ARE THERE ANY CULTURAL ISSUES THAT WE NEED TO BE AWARE OF? (please tick) ☐ YES ☐ NO ☐ DECLINE

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS FORM

PATIENT MEDICAL SUMMARY

Do you have or have you ever had any of the following? Please CIRCLE and provide details:

Heart or Vascular Disorder	NO	YES……..Details……
Heart Murmur	NO	YES……..Year/Details……
Prosthetic Joint Replacement	NO	YES……..Year/Details……
Rheumatic Fever	NO	YES……..Year/Details……
ALLERGIC reaction to drugs/foods/substances	NO	YES……..Details……
Cardiac Pacemaker	NO	YES……..Year/Details……
Epilepsy	NO	YES……..Details……
Fits/Blackouts	NO	YES……..Year/Details……
Stroke	NO	YES……..Year/Details……
Urinary/Kidney Problems	NO	YES……..Details……
Excessive Bleeding	NO	YES……..Year/Details……
Blood Pressure Problems	NO	YES……..Details……
Asthma	NO	YES……..Details……
Kidney Disease	NO	YES……..Year/Details……
Diabetes	NO	YES……..Details……
Hepatitis	NO	YES……..Year/Details……
Jaundice	NO	YES……..Year/Details……
Ulcer	NO	YES……..Year/Details……
High Cholesterol	NO	YES……..Details……
Osteoporosis	NO	YES……..Details……
Bone Disorder	NO	YES……..Details……
Arthritis	NO	YES……..Details……
Cancer	NO	YES……..Year/Details……
Have you suffered any other serious illness?	NO	YES……..Year/Details……
Do you have medication/device that you use in an emergency ? (e.g. Anginine, Epipen, Ventolin)	NO	YES ……
If applicable, are you pregnant?	NO	YES……..How many months?……
Do you consider yourself to be in one of the risk groups for HIV/MRSA/CJD?	NO	YES
Is there anything of a confidential nature you wish to discuss with the Endodontist?	NO	YES

There are many medications that may impact upon your oral health and/or the treatment we plan for you.
Please TICK medications that you are currently taking/taken most recently and PROVIDE DETAILS BELOW:

- ☐ Antibiotics……
- ☐ Heart/Blood Pressure Medication……
- ☐ Hormone Replacement Therapy……
- ☐ Diabetes Medication……
- ☐ The contraceptive pill (may affect blood pressure/clotting & interacts with antibiotics)……
- ☐ Cancer Medication or Therapy……
- ☐ Arthritis Medications or Creams……
- ☐ Anti-inflammatories (e.g. Nurofen, Ibuprofen, Voltaren)……
- ☐ Asthma Medications or Inhalers……
- ☐ Pain Killers (e.g. Aspirin, Panadol, Codeine)……
- ☐ Bisphosphonates (e.g. Didronel, Bonefos, Fosamax, Actonel, Zometa)……
- ☐ Natural Therapies……
- ☐ Nicotine Replacement Therapy……
- ☐ Other Medications……

PRIVACY POLICY

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) and/or models relating to my treatment may need to be sent to other dental practitioners to aid in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check-up reminders. OUR COMPLETE PRIVACY POLICY IS AVAILABLE FOR PERUSAL IN THE PATIENT LOUNGE

TERMS OF PAYMENT

I accept responsibility for my account and understand that the fee is payable on the day of treatment.

PATIENT / PARENT / GUARDIAN SIGNATURE: …… **DATE:** ……/……/……