PATIENT REGISTRATION

HILLCREST HEALTHCARE DENTAL CENTRE

TITLE: SURNAME: FIRST NAME:

DATE OF BIRTH: / / GENDER: ☐ Male ☐ Female

E-MAIL: HOME PHONE:

WORK PHONE: MOBILE PHONE:

ADDRESS: POSTCODE:

OCCUPATION: PLACE OF WORK:

NEXT OF KIN: NEXT OF KIN PHONE:

RELATIONSHIP OF NEXT OF KIN:

MEDICAL HISTORY

NAME OF GENERAL PRACTITIONER: MEDICAL CENTRE:

■ Do you have, or have you had any of the following?

☐ Heart valve repair	☐ High blood pressure	☐ Cancer	☐ Gastric issues
☐ Rheumatic fever	☐ Low blood pressure	☐ Chemotherapy	☐ Epilepsy
☐ Angina	☐ Anaemia	☐ Radiotherapy	☐ Bone disease
☐ Bleeding disorder	☐ Prosthetic joint	☐ Depression/anxiety	☐ Stroke
☐ Other heart trouble	☐ Diabetes	☐ Asthma	☐ Kidney issues

OTHER MEDICAL CONDITIONS:

■ Do you take, or have you ever taken Fosamax, Etidronate or other bisphosphonates? ☐ Yes ☐ No

■ Do you take Warfarin, Pradaxa, Clopidogrel or other blood thinners? ☐ Yes ☐ No

■ If you are taking any other medication, prescribed or non-prescribed, please list:

■ Are you allergic to any medications? If yes, please list below. ☐ Yes ☐ No

■ Have you ever had any contact with HIV, Hepatitis B and/or Hepatitis C? ☐ Yes ☐ No

■ Women, are you pregnant or breastfeeding? If so, how many months? _____ ☐ Yes ☐ No

■ Do you smoke? ☐ Yes ☐ No

Privacy: I understand that this clinical record sheet collects personal and health information about me for the purpose of assessing my medical history prior to my treatment, in order to provide safe dental care. I authorise Hillcrest Dental Centre to collect information from my General Medical Practitioner and/or specialist if clarification or further information is required. I understand that if I give false or misleading information it may affect the treatment provided. All information is collected in accordance with the Privacy Act 1993 and Health Information code 1994.

Terms of trade: Fees for treatment are payable in full at time of delivery. By accepting treatment at this practice you agree to these terms and will pay any costs incurred in recovering outstanding fees.

SIGNED: DATE: / /