Registration Form and Confidential Medial Questionnaire

Please ensure Page 3 is signed appropriately

Title: Mr/Mrs/Ms/Other

Date of Birth ________________

Surname: ________________________________

Given Names: ________________________________

Address: ____

Phone: ________________________________

Mobile: ________________________________

Name of Contact Person (if different to patient): ____

Next of Kin: ______________________________

Relationship to patient: ______________________

Phone: ________________________________

Who is responsible for the account?

Self/WorkCover/TAC/DVA/Other- please specify: ____

Do you (patient) have private health insurance? Yes No

If yes, which fund: ____

Who has referred you to WSND?

Self/Dentist/Doctor/Other- please specify: ____

Please describe current dental problem (if any):

____

____

Please circle any condition you have had in the past or currently have:

Anaemia	Blood Pressure	Heart Disorder	Haemophilia	Pacemaker fitted
Cancer	Cystic Fibrosis	Hepatitis A, B or C	HIV/AIDS	Liver Disease
Arthritis	Artificial Prosthesis	Osteoporosis	Spinal Problems	Taking bisphosphonates
Diabetes	Epilepsy	Headaches	Migraine	Kidney Disease
Sinus Problems	Psychiatric condition	Autism Spectrum Disorder	Anxiety	

If you have any other medical problems, known allergies or developmental conditions or disabilities not covered by this list please detail below, and/or attach a medical summary from your medical practitioner:

____

____

____

Your medical practitioner: ______________________________

Address: ____________________ Telephone: ____________________

Have you been in hospital in the last year? Yes No

____

Are you a smoker? Yes No

Females are you pregnant? Yes No

Please list any medication that you may take on a regular basis or attach a copy of your treatment sheet/drug chart:

____

____

____

Additional information for individuals requiring extra management strategies:

A list of motivating things for the patient (eg toys, iPad, praise):

____

Anything that might alarm or frighten the patient (eg loud noises, bright lights):

____

Strategies to calm the patient if upset:

____

Any other relevant behavioural information:

____

____

Your Health Information

In accordance with *the Victorian Health Records Act 2001* and *Privacy Act*.

WSND respects your right to privacy. It is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed. Our full Privacy and Health Information Policies are located on our website.

Please sign this form as confirmation that you have been informed about our privacy policy, and consent to the use of your health information.

Please note:

- Payment in full is required on day of treatment, where possible.
- Accounts referred to a collection agency or solicitor will have legal costs and commission added to the amount due.
- A cancellation fee may be applied for cancelling an appointment at short notice (within 2 hours) or failing to attend the appointment without notice.

Signed: ____________________________________ Date: __________________________

Please circle:

Self/alternative person responsible for the account (Name): ______________________________

If consent for dental examination is being given by a 'person responsible' (see Office of Public Advocate for full definition) please sign below:

Signed: ___________________________________ Date:____________________________

Name: ____________________________________

Relationship to patient: _______________________ Contact No: _______________________

Email address: ____

Please note: the dental examination may include cleaning and x-rays. Further treatment will require additional consent.