mint dental

Patient Registration & Health Summary Form

Preferred title: _____ **Date of Birth:** ____ /_____ /_____

First Name _____

Last Name _____

Preferred Name _____

Address _____

_____

Suburb _____ Postcode _____

Contact Phone Number _____

Email _____

Patient / Guardian name

(If applicable) _____

Carer name _____

(If applicable)

Contact Phone Number _____

Emergency Contact Name _____

Contact Phone Number _____

Do you have Private Health Insurance? ☐ Yes ☐ No

☐ Hospital ☐ Dental

Fund _____ Ref. Number _____

Department of Veterans Affairs' Card Number

(If applicable) _____

Is this consultation related to Workcover or a Work related injury or Transport Accident? ☐ Yes ☐ No

How did you hear about Mint Dental?

☐ Family? _____ ☐ Internet

☐ Signage

☐ Personal Recommendation? _____

☐ Facebook ☐ Instagram ☐ Other _____

Please take care to fill out this form completely. We rely on your information to provide you with appropriate services.

Privacy Policy – We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Would you like to receive appointment reminders, practice communication and information via Email, SMS and Phone?

☐ Yes ☐ No

Medical History

To the best of your knowledge do you have or have you suffered from the following? If possible please provide approximate date of diagnosis.

Heart ☐ Rheumatic Fever ☐ High Blood Pressure ☐ Heart Surgery ☐ Pacemaker fitted ☐ Heart Murmur ☐ Angina ☐ Thrombosis

☐ Other Heart Conditions _____

_____

Chest ☐ Bronchitis ☐ Emphysema ☐ Pneumonia ☐ Chest Surgery ☐ Smoker ☐ Cystic Fibrosis ☐ Pleurisy

☐ Other Chest Conditions _____

_____

Blood ☐ Bleeding ☐ Hepatitis ☐ H.I.V. ☐ Anaemia ☐ Haemophilia

☐ Other Blood Conditions _____

_____

Other ☐ Diabetes ☐ Liver Disease ☐ Kidney Disease ☐ Epilepsy ☐ Cancer ☐ Pregnant

☐ Other Conditions _____

_____

Please state any major surgery you have had in the last five years _____

Allergies and Adverse Reactions

Do you have any allergies? ☐ Yes ☐ No

Do you have any adverse reactions to drugs? ☐ Yes ☐ No

If Yes, please state allergy/reaction _____

Emergency Plan _____

Medicines

There are many medications that may impact upon your oral health or the treatment we plan for you. Please indicate any medications that you are currently taking or have taken recently (including natural therapies). Alternatively a list from your GP can be attached.

☐ _____ ☐ _____

☐ _____ ☐ _____

Are you on any blood thinners such as Warfarin or Aspirin? ☐ Yes ☐ No

Your appointment time has been reserved exclusively for you. Please provide us with 48 hours notice for any cancellations, otherwise a fee will be incurred.

☐ I agree to be responsible for all payment of fees and understand that payment is due at the time of the service.

Patient/Guardian Signature (if applicable)

_____

Sign _____ Date: ____ /____ /____

Due to ADA requirements we will require this form to be updated every two years.

V 08.19/5