Patient Registration Form

Please complete all fields and return to Reception

K&L DENTALGROUP

Dr ☐ **Miss** ☐ **Ms** ☐ **Mrs** ☐ **Master** ☐ **Mr** ☐

Surname:		**First Name:**	
Address:		**Preferred Name:**	
		Date of Birth:	
	P/code	**Home Phone:**	( ) pref ☐
Postal: (if different)		**Work Phone:**	( ) pref ☐
	P/code	**Mobile:**	pref ☐
Place of Employment:		**Email:**	
If Child, please state Mother / Father / Guardian name			

Would you like to receive a text message reminder for your appointments? Yes ☐ No ☐

Who is responsible for the account? _____

Do you have Private Dental Cover? Yes ☐ No ☐ Fund Name: _____ Line No.:____

How did you hear about our practice?

☐ Personally Recommended By: _____

Signage ☐ Yellow Pages ☐ Web / Internet ☐ Television ☐ Other ☐_____

Emergency Contact:			
Phone:	( )	**Relationship:**	

Privacy Policy

We require the information set out above in order to provide you with effective and efficient dental services. You are entitled to access your information at any time and we will keep your information confidential. However, when necessary, we may pass your information on to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available upon request from Reception.

Terms of Payment

I accept responsibility for my account and understand that the fee is payable on the day of my treatment. Should I be unable to pay on the day, I understand the payment is due within 30 days. If my account exceeds 30 days, I understand an account keeping fee may be incurred. If my account remains overdue and is referred to a debt collection agency or solicitors, I may be held liable for the costs of such collection, plus interest. I accept full responsibility for health fund claims and rejections. Any fees incurred by the practice for cheques not accepted by the bank, may be passed to me.

Photographic Agreement

With your permission, and for the purposes of providing oral health services and education, the practice may take photographs or models as a means of providing examples of treatment and/or oral health care, clinical use or education. Photographs will be modified so that they do not contain identifiable images of people. By signing your acceptance of this agreement you are permitting this practice to adapt or alter the photos without acknowledging your identity and use any such modified photographs in publications, exhibitions or presentations. You also assign all copyright in the photographs to the practice.

Please indicate your permission and agreement to take and use any de-identified photographs. Yes ☐ No ☐

Signed: _____ **Date:** _____

Print Name: _____

Patient Medical History

Please complete all fields and return to Reception

K&L DENTALGROUP

Patient Name:	

Usual Doctor / Clinic:		**Phone:**	
Address:			

Are you currently taking any medication / drug / pill? Yes ☐ No ☐

Please list: _____

Are you aware of having an allergic reaction to any medication or substance? Yes ☐ No ☐

Please list: _____

Indicate which of the following you have had, or have at present. Please tick "Yes" or "No" to each item.

Rheumatic Fever		Yes ☐	No ☐	Asthma	Yes ☐	No ☐
High Blood Pressure		Yes ☐	No ☐	Tumors or Cancers	Yes ☐	No ☐
Tuberculosis		Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Diabetes		Yes ☐	No ☐	AIDS / HIV	Yes ☐	No ☐
Kidney or Liver Disease		Yes ☐	No ☐	Epilepsy or Seizures	Yes ☐	No ☐
Osteoporosis		Yes ☐	No ☐	Excessive Bleeding	Yes ☐	No ☐
Heart Problems		Yes ☐	No ☐	Artificial Joints (hip, knee etc.)	Yes ☐	No ☐
Do you smoke?		Yes ☐	No ☐	If yes: approx. ____ smokes per day for approx. ____ years		
Women: Are you	Pregnant	Yes ☐	No ☐	If yes: ____ months along		
	Nursing	Yes ☐	No ☐	Taking birth control pills	Yes ☐	No ☐

If "Yes" to any of the above, please explain: _____

_____

Do you have any other medical condition, disease or problem not listed? Yes ☐ No ☐

Please list: _____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, the practice has my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Signed: _____ **Date:** _____

Print Name: _____

Send via Email