Patient Registration Form

Patient's Name: _____ _____Mr/Mrs/Miss/Ms/Mst/Dr
(Surname) (First names)

Date of Birth: _____

Address: _____

PARENT/GUARDIAN DETAILS

(If patient under 18)

Mother's name: _____

Mother's address: _____

(If different from above) _____

Mother's contact number: _____

Father's name: _____

Father's address: _____

(If different from above) _____

Father's contact number: _____

_____

Telephone: Home: _____

Work: _____

Cell: _____

Email address: _____

School/workplace: _____

General Dentist: _____

Person who referred you: _____

List other family members who have had Orthodontic treatment:

_____

Send accounts to: Patient Parent/Guardian Other

If other, full details please: _____

Health Questionnaire

- Are you receiving any medical treatment at the present time? Yes/No
- Have you ever been in hospital? If yes, reason _____ Yes/No
- Have you ever had of the following? (Please tick if yes)

Rheumatic Fever Epilepsy Heart trouble
Anaemia Diabetes High blood pressure
Asthma Kidney trouble Severe headaches
Gastric problems Cold sores Hepatitis (A/B/C)
Depressive illness Arthritis Drug dependence
Chest problems Bronchitis

- Are you taking any tablets, capsules, medicines or drugs? Yes/No

If yes, please list: _____

- Do you have any known allergies? Yes/No

If yes, please list: _____

- Are you wearing an artificial or prosthetic joint? Yes/No
- Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes/No
- Have you ever had contact with the AIDS virus or Hepatitis B virus? Yes/No
- Have you ever had a reaction to an anaesthetic? Yes/No
- Women: Are you pregnant now? Yes/No Months _____
- Are there any other aspects concerning your health that you think your Dentist should know about? Yes/No
- Dental habits: Nail biting Thumb sucking Grinding
- Dental accidents/injuries to teeth or jaws? Yes/No

Signed by: Patient/Parent/Guardian_____ Date: _____