Patient Registration Form

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

Date of Birth: _____

Address: _____

_____ Postcode_____

Telephone: Home: _____

Work: _____

Cell: _____

Email address: _____

School/workplace: _____

General Dentist: _____

Person who referred you: _____

List other family members who have had Orthodontic treatment:

_____

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: _____

Send accounts to: ☐ Patient ☐ Parent/Guardian ☐ Other

If other, full details please: _____

Health Questionnaire

1. Are you receiving any medical treatment at the present time? Yes/No
2. Have you ever been in hospital? If yes, reason _____ Yes/No
3. 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	☐		

4. Are you taking any tablets, capsules, medicines or drugs? Yes/No
   If yes, please list: _____
5. Do you have any known allergies? Yes/No
   If yes, please list: _____
6. Are you wearing an artificial or prosthetic joint? Yes/No
7. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes/No
8. Have you ever had contact with the AIDS virus or Hepatitis B virus? Yes/No
9. Have you ever had a reaction to an anaesthetic? Yes/No
10. Women: Are you pregnant now? Yes/No Months _____
11. Are there any other aspects concerning your health that you think your Dentist should know about? Yes/No
12. Dental habits: Snoring ☐ Nail biting ☐ Thumb sucking ☐ Grinding ☐
13. Dental accidents/injuries to teeth or jaws? Yes/No

Signed by: Patient/Parent/Guardian_____ **Date:** _____