

Dr. Lallit Rajpal B.D.S (Otago) & Associates.

The C.O.D.E Group @ 220 Main Rd
'The Centre Of Dental Excellence'

DENTAL REGISTRATION FORM

Please circle: Sir. Dr. Mr. Mrs. Miss. Ms. Master.

Patient Surname: _____ Patient First name: _____ Date of Birth: _____ Age: _____

Address: _____ City/Town: _____

Phone Contacts Hm: _____ work: _____ Mob: _____

Occupation: _____ Email Address: _____

If at School, or a Teaching Institution, please name: _____

Referred By: Family (Name) _____ Friend/Acquaintance: (Name) _____

Yellow Pages, Newspaper, Web Site or Other (please mention) _____

EMERGENCY CONTACT DETAILS

Name of Doctor: _____ Address: _____

Phone: _____ email: _____

Name Of Nearest Friend Or Relative: _____ Phone: _____

Address: _____ City/Town: _____

DENTAL HISTORY

Name of Last Dentist: _____ Date (Approx) Last Attendant: _____

Is This Is ACC Related? _____ Any Previous ACC Dental History? Approx Date: _____

Reason For Attending For This Appointment: _____

Are You In Pain? _____ Are Your Teeth Sensitive To Hot, Cold or Sweet Foods? _____

Do Your Gums Bleed? _____ Do You Consider That You Have Bad Breath? _____

Would You Like Your Teeth Whiter? _____

Is There Any Thing Else We Should Know About Your Teeth Or Oral Health? _____

PERSONAL MEDICAL HISTORY

Do you consider yourself to be in good health? _____ Do you have an existing illness? _____

Have you been hospitalized in the last two years? _____ Do you bleed excessively when cut? _____

Are you presently taking any medication? If so, please list: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING

	Yes	No		Yes	No
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	10. Liver or Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	11. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
3. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	12. Respiratory Ailments (ie Asthma)	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	13. Venereal/Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
5. Prosthetic Devices (eg Hip Joints)	<input type="checkbox"/>	<input type="checkbox"/>	14. HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	15. Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
7. Strokes	<input type="checkbox"/>	<input type="checkbox"/>	16. Are you Pregnant, (if so, how long)	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	17. Any Known Allergies to:	<input type="checkbox"/>	<input type="checkbox"/>
9. Tumor History	<input type="checkbox"/>	<input type="checkbox"/>			

a. Penicillin
c. Local Anesthetics

b. Other Antibiotics
d. Other

FINANCIAL

Person Responsible For Paying This Account _____

Preferred Method Of Payment: Cheque: _____ Cash: _____ Credit Card: _____ Eft-Pos _____

GE Finance: _____

All accounts are to be settled after each treatment.

Please note, that any costs that may be incurred to recover any debts outstanding may be added to your final dental account.

Any General Remarks

By signing here, I indicate that I have understood the above contents and am fully informed as to the contents of this document. Further, I consent to and authorise Dental Health Care, including administration of local anesthesia, X-ray examination, and other related dental procedures provided by the Professional and Auxiliary Dental Staff of CODE Group.

Signature: _____ Date: _____ P.T.O

Any Further Information: _____



Dr. Lallit Rajpal B.D.S (Otago) & Associates.

**The C.O.D.E Group @ 220 Main Rd
'The Centre Of Dental Excellence'**