DENTAL REGISTRATION FORM

The Centre of Dental Excellence, 220 Main Rd, Tawa, Wellington
P: 04 2328001: F: 04 2328005: M: 0274 545 475 E: Wellington@dental.net.nz

THE C.O.D.E GROUP

'THE CENTRE OF DENTAL EXCELLENCE'

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

Patient Surname_____ Patient First name _____

Date of Birth_____ Age _____

Address _____

City/Town _____

Phone Contacts Hm:_____ Wk:_____ Mob:_____

Email Address_____

Occupation_____

If at School, or a Teaching Institution, please name_____

Referred By: (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 _____

Address _____

City/Town _____ Phone: _____

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? _____

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?	YES	NO
Do you have an existing illness?	YES	NO

If Yes, please describe: _____

Have you been hospitalized in the last two years?	YES	NO
Do you bleed excessively when cut?	YES	NO
Are you presently taking any medication?	YES	NO

If so, please list and for what medical condition:

_____

_____

_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

Circle which apply

1. Heart Disease
2. High Blood Pressure
3. Rheumatic Fever
4. Heart Murmur
5. Prosthetic Devices (eg Hip Joints)
6. Diabetes
7. Strokes
8. Epilepsy
9. Tumor History
10. Liver or Kidney Diseases
11. Hepatitis
12. Respiratory Ailments (ie Asthma)
13. Venereal/Sexually Transmitted Diseases
14. HIV or AIDS
15. Cold Sores
16. Are you Pregnant, (if so, how long)
17. Any Known Allergies to:-
    a. Penicillin
    b. Other Antibiotics
    c. Local Anesthetics
    d. Other

FINANCIAL

**** The Practice is a strict payment on the day Practice unless approved by the Dental Practice Principal****

Person Responsible For Paying This Account _____

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

Auto Payment: _____ Finance Company: _____

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

By signing or ticking the terms of conditions, I indicate that I have the understood the above contents and am fully informed as to the contents of this document. Further, I consent to and authorise the Dentists at the CODE Group to, the administration of local anesthesia, take X-rays and other related dental procedures as provided by the Professional and Auxiliary Dental Staff of the Centre of Dental Excellence

By ticking the Box, I understand I agree to the above terms: ☐

Signature: _____ Date: _____