EraHealth

PRIVATE PATIENT REGISTRATION FORM

PATIENTS DETAILS

Title ________ First Name ____________________ Surname ______________________________

D.O.B ______________ Address ____________________________ Suburb ________________ Post code ______

Phone No: (H)________________ (W) ________________ (M) ______________________________

Email __________________________ Employer ____

Referrer's Name ______________________________ Phone ____________________________________

Next of Kin or Parent/Guardian ___________________________ Phone _____________

Emergency Contact ____ Phone _____________

TAC / Work Cover (circle) Claim No ____

Medicare No _______________________ Ref No ________ Expiry ______________________________

Private Health Insurance YES NO If yes, name of fund ______________________ Membership No_______________

Are you of Aboriginal or Torres Strait Island descent? NO/YES if yes ____

Pension, Health Care or Veterans Affair card No.(if applicable) __________________________ exp:_____________________

How did you hear about us? (please tick the box)

- ☐ **Word of Mouth**
- ☐ **Yellow Pages**
- ☐ **Google Search**
- ☐ **Health Fund**
- ☐ **Brochures**
- ☐ **Signage**
- ☐ **Employer**
- **Other** ________

CONSENT

I consent to the use of my personal health information by the Era Health and other health providers involved in my medical treatment and health care.

I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

Our Practice uses a reminder system to improve the quality of your health care and to promote preventative health care. Our practice routinely sends out health related newsletters, reminder emails and we telephone and send SMS reminders for appointments and procedures including vaccinations, PAP tests and other health reviews. You may opt out of receiving any or all of these communications at any time.

CANCELLATION POLICY

We require at least 12 hours notice to cancel or change your appointment. Failure to give this notice may result in a cancellation fee of $70 being charged.

PAYMENT OF THE CANCELLATION FEE IS REQUIRED WITHIN 7 DAYS

I, ________________________ have read and understood the above condition of being a patient at this practice, and agree to pay the cancellation fee should I cancel without giving 12 hours notice. I acknowledge that the information given on this form is true and accurate to the best of my knowledge.

Signature ______________ **Date** ______________

FOR ERA HEALTH USE ONLY

ENTERED BY: **CHECKED BY:** **DATE:**

EraHealth City
a new era in total patient care

Medical and Dental History Form

Title: Mr / Ms / Miss / Mrs / Dr D.O.B. ____________________

Surname: ____

Given name(s): ____

Important: Some procedures and medications used in dentistry may be unsafe for you if we were not made aware of your medical conditions. To assist in tailoring dental treatment to your needs, your Dentist needs to collect personal information about your medical and dental history. There may be circumstances where the information could be disclosed to other treating health practitioners, such as if you require specialist dental treatment. If you are unsure of the implications of signing this form, please discuss your concerns with your Dentist.

	Yes	No
Have you had major surgery or been in hospital in the last 12 months?		
Are you currently under the care of a doctor or medical specialist for any reason?		
Are you taking or have recently taken any medications or health supplements?		
Have you ever had an allergic or adverse reaction to any drugs or substances? (eg. Penicillin, iodine, latex)		
Have you ever had complications with general anaesthetics, local anaesthetic injections or laughing gas?		
Have you ever had problems or complications during or after dental treatment?		
Have you ever been diagnosed or tested positive for an infectious disease? (eg. HIV, AIDS or hepatitis)		
Do you smoke or use tobacco? If yes, number per day ____________		
Are you pregnant? If yes, due date: ____________		
Are you breastfeeding?		

Have you ever had any of the following conditions? (please tick)

- ☐ Heart murmur
- ☐ Heart valve abnormality
- ☐ Rheumatic fever
- ☐ Infective endocarditis
- ☐ Irregular heartbeat
- ☐ Heart attack, angina or chest pain
- ☐ High or low blood pressure
- ☐ High cholesterol
- ☐ Asthma or hay fever
- ☐ Sleep apnoea
- ☐ Other respiratory diseases
- ☐ Seizure, stroke or depression
- ☐ Diabetes or thyroid disease
- ☐ Stomach ulcer or gastric reflux
- ☐ Gall bladder problems
- ☐ Hepatitis or liver disease
- ☐ Kidney disease
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Back problems
- ☐ Tumour or cancer
- ☐ Prolonged bleeding from a cut
- ☐ Blood disorders
- ☐ None of the above

Is there anything you would like to change about your smile? ____________________

I declare that to the best of my knowledge the information provided in this form is true and correct.
I acknowledge that the information provided in my medical and dental history form may be used or disclosed for the purpose of tailoring dental treatment to my needs.

Patient signature: ____________________ **Date:** ____________________