New Patient Registration Form

First Name _____ Surname _____ Gender _____
Address _____
Suburb_____ State_____ Postcode_____
Date of Birth _____ Mobile _____
Home Phone _____ Work Phone _____
Email _____ Occupation _____
Health Insurance _____
Date of Joining Health Insurance _____
Membership Number _____
Family Doctor Name _____
Who Refered You To This Surgery? _____
When Was Your Last Dental Visit? _____

MEDICAL AND DENTAL HISTORY	***YES***	***NO***
Are you in poor general health?		
Are you under medical treatment?		
Are you taking any medication?		
Do you have high or low blood pressure?		
Have you had a blood transfusion?		
Have you ever had a general anesthetic?		
Are you currently or have taken Aspirin?		
Allergic to any medicines, drugs, food and etc?		
Do you suffer from Hay Fever, Eczema or Asthma?		
Have you ever had Rheumatic Fever?		
Abnormal bleeding after extraction or injury?		
Steroid, Anticoagulant or Irradiation therapy?		
Jaundice, Hepatitis or other liver diseases?		
Do you have sudden fainting attacks or giddiness?		
Are you at high risk of contracting AIDS?		
For women if pregnant, state months		

HAVE YOU EVER HAD ANY OF THE FOLLOWING?
If "Yes", Please "Circle"

Chicken Pox	Measles	Mumps
Heart Disease	Blood Disease	Tuberculosis
Hypertension	Kidney Disease	Epilepsy
Diabetes	Tyroid Disease	Hepatitis
Stroke	Ulcer	

SIGNATURE _____ DATE _____

PLEASE NOTE: In order to deliver our best services, Blossom Dental Care requires you to fill out this form. This information will be handled confidnetially.

OFFICE USE ONLY: REGISTRATION CARD NUMBER