Integrated Dental Health
A Holistic Approach

New Patient Registration Form

Please feel free to ask reception if you have any questions about this form.
If you are under 18, please ensure a parent or guardian completes this form on your behalf.

Contact Details			
Title:	Full name	Date of Birth:	
Occupation:			
Parent/guardian (if child/disability):			
Address:			
Suburb:		Postcode:	
Home phone:		Mobile:	
Email:			
How do you prefer your appointment/treatment reminders?		SMS □ Email □	

Medical history(current of history of)			
□ Rheumatic fever	□ Kidney problems	□ Anaemia / blood disorders	Other:
□ Diabetes	□ Liver problems	□ Sleep apnea/breathing issues	
□ Low/high blood pressur	□ ADHD/sensory issues	□ Autoimmune disease	
□ Malaria	□ Gastric reflux	□ Creutzfeldt Jacob disease	
□ Epilepsy	□ Heart conditions	□ Artificial joint (in last 2 years)	
□ Anxiety/depression	□ Asthma	□ Are you pregnant ?	
□ Cancers	□ Motor neuron disorders		
Please list any medications you're taking:			
Please list any allergies:			
Have you ever had an unfavourable reaction to local or general anaesthetics?		□ Yes □ No	

Dental History (write Y/N as applies)	
□ Dental phobia/history of bad dental experience	□ Do you suffer from headaches?
□ Does your jaw click or hurt?	□ Do you experience sensitivity with hot or cold?
□ When was your last dental check up?	□ Do your teeth hurt when you bite hard?
□ History of gum disease / do your gums bleed ?	□ Do you feel you grind or clench your teeth?
□ Do you smoke?(how many per day /how long)	□ Do you wear a dental night guard?
□ Do you bite your lips or cheeks often?	□ Do you think you have occasional bad breath?
□ Does floss ever tear between your teeth?	□ Does food get trapped between your teeth?
□ How often do you brush your teeth?	
□ How often fo you floss?/use Piksters/water irrigator?	
Are you happy with the appearance of your teeth?	□ Yes □ No
If not, how would you like us to help	

Consent For Treatment

1. I hereby authorise the dental practitioners to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis.
2. Upon such diagnosis, I authorise the dental practitioner to perform all recommended treatment mutually agreed upon by me.
3. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that full payment is due at the time of service unless other arrangements have been made.
4. Do you mind if we send you newsletters? No □ Yes □

Patient/Guardian Signature: _____ Date ___/___/_____

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Welcome to Integrated Dental Health

Our team are dedicated to providing you with gentle & complete dental care in a relaxing environment.

We believe treatment should integrate as closely as possible with the body's processes and structures. Our dentists look at the effects of dental disease on your general health and vice versa to achieve the best outcome. We use materials and procedures that work in harmony with your body, caring for your overall health & well being.

We are not a radical holistic dental practice, and, in order to get a better understanding as to what your expectations are, please help us by completing the details below and overleaf.

How holistically minded are you?

Routine dentistry is all I need	1	2	3	4	5	6	7	8	9	10 **I want all the holistic options available**

Please list any specific holistic needs you wish to discuss with the dentist

How do you feel about seeing the dentist?

Please indicate on this chart where you feel is the most applicable to you:

Relaxed	1	2	3	4	5	6	7	8	9 **Extreme Fear**

Are you interested In any of the following services?

□ Facial fillers/botox	□ Safe amalgam removal
□ Ceramic restorations	□ Naturopathic consult prior to amalgam removal
□ Whitening	□ Implants
□ Treatment under sedation/ anxiety reduction treatment/hypnosis with	
□ Multidisciplinary consultation with allied health practitioners	

How did you hear about us? (please circle)

□ Walked by	□ Internet	□ Facebook	□ Newspaper	□ Word Of Mouth	□ Other (please specify)

Private health fund details

Name of health fund:	
Membership number:	What number are you listed on the card:

please turn over->—>—>