Dr. Cherian Thomas and Dr. Leena Cherian
Shop 32
269-293 Lake Albert Road
WAGGA WAGGA 2650
02-69226840

NEW PATIENT REGISTRATION

SURNAME: _____

TITLE: DR PROF MR MASTER MISS MRS MS

GIVEN NAMES: _____

PREFERRED NAME: _____

DATE OF BIRTH: _____

HOME PH: _____ MOBILE PH: _____ WORK PH: _____

ADDRESS: _____

TOWN: _____ POST CODE: _____

OCCUPATION: _____ COMPANY: _____

EMAIL:_____

DENTAL HEALTH FUND NAME: _____ DENTAL HEALTH FUND NUMBER: _____

HEALTH FUND SERIES NUMBER: _____

MEDICARE NUMBER: _____ MEDICARE POSITION: _____

VETERANS AFFAIRS NUMBER: _____

SENIORS CARD NUMBER: _____

INCASE OF AN EMERGENCY WHO SHOULD WE CONTACT? _____

RELATIONSHIP TO YOU: _____

EMERGENCY CONTACT NUMBER: _____

HOW WOULD YOU LIKE TO BE CONTACTED FOR YOUR APPOINTMENTS PHONE / SMS

WHO REFFERED YOU TO OUR PRACTICE: _____

PLEASE TURN OVER

KOORINGAL DENTAL
ALL YOUR DENTAL NEEDS + Orthodontics

MEDICAL HISTORY

		MEDICATION TAKEN
HIGH BLOOD PRESSURE	Y / N	_____
LOW BLOOD PRESSURE	Y / N	_____
HEART CONDITION – MURMUR/ ANGINA	Y/ N	_____
RHEUMATIC FEVER/ HEART VALVE PROBLEMS	Y / N	_____ _____
BLOOD THINNING MEDICATION	Y / N	_____
DIABETES	Y / N	_____
EPILEPSY/ STROKE	Y / N	_____
ASTHMA/ HAYFEVER/ SINUS (PLEASE CIRCLE)	Y/ N	_____
THYROID DISORDER	Y / N	_____
IMMUNE SYSTEM DISORDER	Y / N	_____
DEPRESSION / MENTAL ILLNESS	Y / N	_____
HIV, HEPATITS A, B OR C?	Y / N	_____
BLEEDING DISORDERS	Y / N	_____
DIZZINESS/ FAINTING	Y / N	_____
GASTRIC DISORDER/ REFLUX	Y / N	_____
RADIOTHERAPY/ CHEMOTHERAPY	Y / N	_____
DO YOU TAKE ANY OTHER MEDICATIONS?	Y / N	_____
DO YOU SMOKE?	Y / N	
ARE YOU PREGNANT	Y / N	DUE DATE? _ __ /_ __ /___
PACEMAKER/ HEART SURGERY	Y / N	
LIVER/ KIDNEY DISORDER	Y / N	
OSTEOPOROSIS	Y / N	

DO YOU HAVE PROBLEMS WITH GENERAL ANAE STHETICS	Y / N
HAVE YOU HAD A DIFFICULT TOOTH EXTRACTION	Y / N
DO YOU EXPERIENCE PROLONGED BLEEDING	Y / N
BEFORE DENTAL TREATMENT ARE YOU REQUIRED TO TAKE ANTIBIOTIC PROPHYLAXIS	Y / N
DO YOU SUFFER FROM CLICKING JAW/ CLINCHING/ JAW PAIN	Y / N

ARE YOU ALERGIC TO ANY MEDICATION? Y / N **IF SO, WHICH? _____**

PLEASE LIST ANY OTHER MEDICAL CONDITION NOT LISTED ABOVE: _____

IS THERE ANY HEALTH MATTERS YOU WOULD LIKE TO DISCUSS PRIVATELY?_____

WHO IS YOUR DOCTOR (GP): _____ PHONE NUMBER: _____

PATIENT SIGNATURE: _____ DATE: _____