WODEN DENTAL CARE

Suite 15, Corinna Chambers
Woden, ACT 2606
Tel. 02-6282 8558

Registration Form

Title: _____ Surname: _____ First Name:_____Preferred Name: _____
D.O.B:_____ Occupation:_____ Referred by: _____
Home Address: _____ Postcode: _____
Email: _____Phone No:_____
Emergency Contact Person: _____ Phone No: _____
Family Doctor/Medical Centre: _____Phone No: _____
Cultural Background: ☐ Aboriginal or Torres Strait Islander ☐ Other: ☐ Prefer Not to Say
Health Fund Details: _____ Hospital cover: Yes/ No Dental cover: Yes / No

Please answer the following medical questionnaires.	**Yes**	**No**
• Are you at present receiving medical attention?	☐	☐
• Are you at present taking any medication? Details: _____	☐	☐
• Do you smoke?	☐	☐
• Are you pregnant? (Female only)	☐	☐
• Do you have any known allergies? Details: _____	☐	☐
• Have you ever had or suffered from any of the following medical conditions?		
○ Rheumatic fever	☐	☐
○ Heart disorder (heart murmur), chest pain	☐	☐
○ Pacemaker/Cardiac surgery	☐	☐
○ Blood pressure	☐	☐
○ Diabetes	☐	☐
○ Osteoporosis Prolia (last injection date: _____)	☐	☐
○ Epilepsy	☐	☐
○ Stomach ulcer/Hiatus hernia	☐	☐
○ Asthma	☐	☐
○ Bronchitis	☐	☐
○ Radiotherapy/Chemotherapy	☐	☐
○ Organ transplant	☐	☐
○ History of prolong bleeding/blood disorder	☐	☐
○ Blood or other transfusions	☐	☐
○ Hepatitis (A, B, C, D), AIDS, or HIV	☐	☐
○ Other communicable diseases including Measles, Chickenpox, TBs	☐	☐
○ Respiratory Diseases: RSV, COVID, Influenza	☐	☐

When was your last dental visit? _____ What treatment was provided? _____
What is the purpose of your visit today? Please circle your answer.
Check-up/Toothache/Bleeding gum/Broken tooth/Improving smile/others_____
How did you find us? _____

Declaration:

- ✓ I declare that the information contained in this form is correct and complete and will inform you of any future changes.
- ✓ I acknowledge my responsibility for the full payment of dental care on the day of service. This payment is independent of any benefits claimable from Private Health Insurance.

Signature of the Patient/Parent: _____ **Date:** ____/___/_____

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Wellbeing & Support Screening Form

This form helps us understand aspects of your comfort, communication and general wellbeing so we can provide safe, respectful and holistic dental care. You have the right to:

- Make your own decisions about treatment.
- Be heard and have your preferences respected.
- Receive care that is safe, supportive and culturally appropriate.

Patient Self-Assessment Questions (Please tick the option that best applies)

1. Have you experienced worry, stress or nervousness about dental treatments recently?
   ☐ Yes ☐ No ☐ Not sure
2. Do you feel particularly anxious or fearful about **needles or dental procedures**?
   ☐ Yes ☐ No ☐ Not sure
3. Are you currently receiving support from a health professional (e.g., psychologist, GP, counsellor)?
   ☐ Yes ☐ No ☐ Not sure
4. Are you taking any medication that supports your mood, sleep or general wellbeing?
   ☐ Yes ☐ No ☐ Not sure
5. Do you ever have challenges with concentration, memory or clear thinking?
   ☐ Yes ☐ No ☐ Not sure
6. Would you like extra support to feel more comfortable during your dental appointment?
   ☐ Yes ☐ No ☐ Not sure

Patient / Guardian Name: _____

Signature: _____ **Date:** _____

Clinician Observations & Assessment: (CLINICIAN ONLY)

- **Notes / Observations:** _____
- **Decision-making capacity:**
  ☐ Intact, no support required ☐ Possibly requires support
  • Support required (if any): ☐ Carer involvement ☐ Local support services
- **Managing anxiety or stress**:
  ☐ Reassurance ☐ Shorter appointment ☐ Sedation options
- **Needle/dental phobia support**
  ☐ Gentle desensitisation ☐ Additional explanation time ☐ Sedation options
- **Ongoing healthcare support**
  ☐ Not required ☐ Contact treating clinician (with consent) ☐ GP follow-up

Clinician Signature: _____ **Date:** ___/___/____