Lumino Smiles Dental

In order to render dental treatment of a high standard, it is necessary to have the following information which will be handled in the strictest confidence. Please complete this Registration Form.

Title: ..... First Name: ..... Surname: .....

Preferred Name: ..... Gender: □ Male □ Female Date of Birth: ..... / ..... / .....

Street Address: ..... Post Code: .....

Home Phone: ..... Work Phone: ..... Mobile Phone: .....

Email address: .....

Occupation: ..... Employer: .....

Name of Person responsible for Fees if patient is under 18 years old: .....

Relationship: ..... Contact Number: .....

Address (if different from above): .....

Emergency Contact & Number: ..... Relationship: .....

Name of Private Health Fund (if any): .....Member ID:.....Reference No.:.....

How did you find out about us? Start /Expiry Date:.....

□ Health Fund □ Internet □ Newspaper ..... □ Other (please specify) .....

□ Friend / Family (please provide name so we can thank them) .....

Item numbers on our Statement represent as accurately as possible the procedures performed, but in no way are they a claim on anyone other than the patient for whom they were performed. The eligibility of the patient, or the procedures, to attract refunds, and the rates of those refunds, are determined by the conditions of the patient's Health Insurance Policy. We accept no responsibility, to either party, for any decision the insurer may make regarding the refund of monies to the patient.

Have you ever had any of the following? (Tick those that apply)

□ Rheumatic Fever	□ Heart Murmur	□ Heart Surgery	□ Pacemaker
□ Kidney Disease	□ Diabetes	□ Cardiac Problems	□ Asthma
□ Liver Disease	□ Hepatitis	□ Jaundice	□ Fainting Attacks
□ Heart Problems	□ Epilepsy	□ Lung Problems	□ Hypertension
□ Tuberculosis	□ Stomach Problems	□ Bowel Problems	□ AIDS/HIV

Have you had any of the following:

□ Bad Reaction to GA or LA □ Recent Blood Test/Inoculations □ Taken Steroids in the last 2yrs

□ Had a blood borne infection □ Had a joint replacement

	YES	NO
Are you under current medical treatment? (Please list).....	□	□
Are you taking any medications? (Please list).....	□	□
Female patients: are you pregnant?	□	□
Do you have any allergies?	□	□
List any medicines or products you are allergic to (e.g. Penicillin, Latex)	□	□
Have you or a close family member suffered from gum disease?	□	□
Are you happy with the appearance of your teeth?	□	□
Are you happy with the appearance of your smile?	□	□
Are you happy with the colour of your teeth?	□	□
Do you have frequent headaches, neck or shoulder pain? Do you suffer from migraine?	□	□
Do your jaws ache at times? Is there a clicking sound when you open your mouth wide?.....	□	□
Do you have botox or fillers done on any part of your face or lips?	□	□
Do you snore?	□	□

I have completed this Registration Form to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and checkup reminders.

I understand that Lumino Smiles requires at least 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee of $50.00 could be incurred if I fail to do so.

I am aware that payment is required ON THE DAY of treatment and that it is my responsibility to check with my Health Fund regarding my dental benefits.

I acknowledge that if an account is overdue, Lumino Smiles Dental reserves the right to refer the account to a third party. I agree to meet all reasonable costs incurred by Lumino Smiles Dental in employing the said third party to collect the overdue account.

Signed: ..... Date:.....