PATIENT HISTORY SHEET

Surname: _____ Title: Dr Mr Mrs Ms other_____
Other Names: _____ Preferred Name:_____
Date of Birth: _____
Home Address: _____
_____P/Code: _____
Home Ph: _____ Mobile: _____ Business Ph: _____
Email: _____
Postal Address: (if different to above) _____

Payment of the account is required on the day of treatment. To whom should we make your account payable? _____
Address (if different to above): _____
_____

DVA and Medicare Child Dental Benefits Scheme patients, we will claim online, do we have your authorisation to use your DVA file/Medicare number to complete the online claim for your account? Yes/No

Emergency Contact: _____ Relationship: _____
Ph: _____

Medical Doctor: _____
Address: _____ P/Code: _____ Ph: _____

Who recommended this practice to you? _____

Do you have Dental Extras Insurance? (please circle) Yes / No
Fund Name: _____

Notice to Insured Patients Regarding Dental Benefits Insurance

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?

	YES	NO		YES	NO
High or low blood pressure	□	□	Diabetes	□	□
Heart ailment	□	□	Thyroid problems	□	□
Rheumatic fever	□	□	Excessive bleeding/blood disorders	□	□
Asthma, chest or breathing problems	□	□	Epilepsy or seizures	□	□
Tuberculosis	□	□	Hepatitis A B C (Please Circle)	□	□
Stomach or bowel problems (eg ulcer)	□	□	AIDS/HIV	□	□
Arthritis	□	□	Anaemia	□	□
			Kidney disease	□	□
			Osteoporosis	□	□

If you answered yes to any of the above, please detail:
_____
_____

Do you smoke? Yes / No How many: _____/day Would you like to stop? Yes □ No □

Please list any other previous illnesses: _____

Please turn over

Do you have: an artificial hip, heart valve or other prosthetic implant? Yes □ No □
Please list: _____

Are you taking any medication for your bones? Yes □ No □
Please list:_____
Have you ever had problems with dental treatment? Yes □ No □
Please outline: _____
Are you presently under regular medical care? _____ Yes □ No □
Are you taking any drugs, or medications (including non prescription drugs)? Yes □ No □
Please list:_____
_____
Female patients, are you pregnant or family planning? Yes □ No □

Do you have allergies (Including medicines/products e.g. Penicillin, nickel, codeine or Latex)? Yes □ No □
If so please list: _____

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED.

YOUR HEALTH INFORMATION – PRIVACY CONSENT FORM

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

Our Practice respects your rights to privacy. We realize that it is important that you understand the purpose for which we collect details about your health, as well as how this information us used at our Practice and to whom this information might be disclosed.

The policy of the practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.
2. We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.
3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen your personal identity will not be disclosed without your consent to do so.
4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or written summary, our usual fees apply to these services.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

My signature below is confirmation that I have read and understand the privacy policy and consent to the use of my health information in this way. I understand that I am responsible for my account and payment is required on the day of treatment, payment can be by way of cash, EFTPOS, Mastercard, Visa, Amex or by prior arrangement via direct deposit or a payment plan.

I have completed this Questionnaire 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 clinical notes, radiographs (X-rays) or models relating to my treatment may need to be sent to other medical 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. A fee may apply for appointments cancelled with less than 24 hours notice.

Signed: _____

Date: _____

Patient/ Parent/ Guardian Name: _____

If completing on behalf of a dependent, please print their name:_____