

New Patient History Sheet

In order for this dental practice to provide the highest standard of care, please fill in this form carefully and thoroughly.

Please Print

Surname:	Title: (e.g. Mr/Ms/Mrs/Miss/Dr/Prof etc)
Other Names:	
Preferred Name:	Date of Birth:
Home Address:	
P/Code:	Home Telephone:
Mobile:	Work Number:
Postal Address (if different to above):	
Email Address:	
Name of Person responsible for Fees:	
Address if different to above:	
Emergency Contact:	Relationship:
Address:	P/Code: Ph:
Medical Doctor:	
Address:	
P/Code: Ph:	
How did you find out about us?	

Have you ever had any of the following? Y or N

High blood pressure:	Diabetes:
Heart ailment:	Thyroid problems:
Rheumatic fever:	Tuberculosis:
Epilepsy:	Kidney disease:
Hepatitis:	AIDS/HIV:
Excessive bleeding or blood disorder:	
Asthma, chest or breathing problems:	
Stomach or bowel problems (e.g. ulcer):	
Do you have an artificial hip, heart valve or other prosthetic implant?	
Female patients, are you pregnant?	
Do you smoke?	If so, how many a day? :
Are you on any medications? Please List:	
.....	
Please list any medicines or products you are allergic to (e.g. Penicillin, Latex):	
.....	
List any other previous illnesses:	
Have you ever had problems with dental treatment?	
Do you snore?	Do you wear a night guard?
Do you have sensitive teeth?	
Do you suffer from a dry mouth?	<i>Please Turn Over ...</i>

Your Health Information – Privacy Consent Form

In accordance with the Victorian Health Records Act 2001 and Federal Policy Act 1998.

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

The policy of our 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 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 minimised 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 a 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 upmost 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 concerns with our practice.

I have read this form and sign it as a confirmation that I have understood your privacy policy, and consent to the use of my health information in this way.

I have also 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 also understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other practitioners to aid them in my treatment and consent to this.

Signed..... Date.....

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED