Dental **O**n **V**ictoria, Patient Information Sheet
Please fill in this form carefully and thoroughly.

LAST NAME: _____ **FIRST NAME**: _____

DATE OF BIRTH: _____/_____/_____ **AGE**: _____

HOME ADDRESS: _____

SUBURB: _____ **P/CODE**:_____

HOME PHONE NUMBER: _____ **MOBILE NUMBER**_____

EMAIL ADDRESS: _____**OCCUPATION**: _____

WORK CONTACT NUMBER:_____

EMERGENCY CONTACT: _____ **PH NUMBER**: _____

NAME OF PERSON RESPONSIBLE FOR FEES: _____

DO YOU HAVE: PRIVATE HEALTH INSURANCE **Y / N** COMPANY: _____

HOW DID YOU FIND OUT ABOUT US? _____

MEDICAL QUESTIONS.

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (***TICK WHERE APPROPRIATE***)

HIGH BLOOD PRESSURE	☐	**KIDNEY DISEASE**	☐	**RHEUMATIC FEVER**	☐
DIABETES	☐	**HEART AILMENT**	☐	**THYROID PROBLEMS**	☐
EPILEPSY / FITS / STROKE	☐	**HEPATITIS**	☐	**AIDS / HIV**	☐
ASTHMA	☐	**TUBERCULOSIS**	☐	**BONE DISORDERS / DISEASES**	☐
EXCESSIVE BLEEDING	☐	**BLOOD DISORDER**	☐	**SMOKER**	☐

FOR FEMALE PATIENTS ARE YOU PREGNANT, IF YES HOW MANY WEEKS:_____

HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESSES OR OPERATIONS? **Y / N**_____

HAVE YOU EVER HAD ANY PROBLEMS FOLLOWING DENTAL TREATMENT? **Y / N**

ARE YOU TAKING ANY DRUGS, MEDICATIONS OR TABLETS? **Y / N IF YES, PLEASE LIST:**_____

_____

DO YOU HAVE ANY ALLERGIES (DRUGS, MEDICINES, LATEX) **Y / N** _____

NAME & PHONE NUMBER OF MEDICAL DOCTOR: _____

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 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 authorise my insurance benefits to be paid directly to the provider, and allow the provider to release any information required to participating insurance companies for the processing of my claims. I also understand that I am financially responsible for any outstanding balance.

I understand that I will be responsible for any debt collection fees that may result if I fail to finalise my account by the requested date.

Patient / Guardian signature (if patient under 18): _____Date: _____

Printed Name (Use Block Capitals): _____

***** PLEASE TURN OVER *****

Dental **O**n **V**ictoria
Suite 10, Level 1, 520-528 Victoria St,
North Melbourne, Vic 3051
Tel: 03 9 600 9025 Fax: 03 9 600 9023

Your Health Information - Privacy Consent Form

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

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 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 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 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.

Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Signed: _____

Dated: _____

Patient or Parent / Guardian Name: _____

Child or Dependants Name: _____

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