HOVE DENTAL

Welcome to our practice

The answers to these questions are Confidential and will assist us in providing the best Dental Treatment for our Patients.

Personal Details

Full Name: _____ (Title) _____ (Christian Name) _____ (Surname)

Address: _____

Suburb: _____ Postcode: _____ Date of Birth: _____

Contact No: Home: _____ Mobile: _____

Do you have a regular doctor: _____ Doctor's Contact No: _____

Occupation: _____

Employer: _____ Contact No: _____

Are you covered by Dental Benefits? Yes/No _____ Name of Fund: _____

Emergency Contact / Next of kin / Contact Name: _____ Contact No: _____

Person responsible for account: _____

Medical History

Do you/or have you suffered: (please circle)

1. Heart Murmur?	Yes/No	8. HIV/AIDS	Yes/No
2. Heart / Vascular Disorder?	Yes/No	9. Epilepsy	Yes/No
3. Rheumatic Fever?	Yes/No	10. Organ Transplant	Yes/No
4. High/Low Blood Pressure	Yes/No	11. Joint Replacement	Yes/No
5. Diabetes	Yes/No	12. Liver/Kidney Disease	Yes/No
6. Asthma	Yes/No	13. Osteoporosis	Yes/No
7. Hepatitis	Yes/No	14. Thyroid Problems	Yes/No
		15. Allergies including Antibiotics	Yes/No

Any other serious illness? Please specify _____

Have you ever had any surgery?

Have you experienced:

1. Abnormal bleeding?	Yes/No	
2. Difficult extractions?	Yes/No	
3. Unfavourable reaction to local anaesthetics	Yes/No	
Are you currently taking any medication? (Including Non-prescription)	Yes/No	Please specify _____
Are you a smoker?	Yes/No	
Females: Are you pregnant or trying to get pregnant?	Yes/No	

Payment of Dental Services

Full payment is required for Dental Services rendered at the completion of each dental visit. However, in the event that collection action is required, it is a term of the provision of these services that the patient shall be liable for all debt collection fees and other charges, including but not limited to, agent's fees, solicitor's costs and disbursements.

Signed _____ Date _____

Thank you for your co-operation in providing the above information

PTO

HOVE DENTAL

Incorporating Warradale Dental Surgery

YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY

In accordance with the 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 on this form 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 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, it 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 patient history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of your treatment records at anytime, or seek an explanation from the dentist. If you want copies a fee may apply. If you require an explanation of your records or a written summary, a consultation fee or other charge may apply.

5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You may otherwise be 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.

Name: _____

Signature: _____

Date: _____

Office use only. Yearly review. Please check details - Initial and date changes.

Date: _____ Sign: _____

Date: _____ Sign: _____

Date: _____ Sign: _____

Date: _____ Sign: _____