Welcome, so that we may provide you with the best possible care please complete all sides of this medical history form. All information is completely confidential.

Please circle: MR / MASTER / MRS / MISS / MS / DR

SURNAME:……..FIRST NAME:.....

PREFERRED NAME:.....

ADDRESS:…….....

SUBURB……POSTCODE:.....

HOME NUMBER:…….....MOBILE:.....WORK:.....

EMAIL:……..

DATE OF BIRTH:…….....DRIVERS LICENCE NUMBER:…….....

Do you have any special cultural or spiritual needs? O No O Yes ……

On a scale of 1-10, how would you describe your level of anxiety about your visit today?
Least 1 2 3 4 5 6 7 8 9 10 Most

DOCTOR NAME:…….....

ADDRESS:…….....PHONE:.....

EMERGNCY CONTACT: NAME:…….....PHONE NUMBER:…….....

PLEASE NOTE THAT OUR POLICY IS TO RECEIVE PAYMENT ON THE DAY OF YOUR TREATMENT
WE ACCEPT CASH, EFTPOS, VISA, MASTERCARD AND AMERICAN EXPRESS

ARE YOU AWARE THAT FULL PAYMENT ON THE DAY IS REQUIRED? YES / NO

NAME OF PERSON RESPONSIBLE FOR FEES (if under the age of 18)…….....

ADDRESS:…….....PHONE:.....

Cancellations: 48hrs notice of any cancellation is kindly required or a cancellation fee may be charged.

Patients who have dental insurance: item numbers are used as accurately as possible to describe the treatment received but cannot be claimed for anyone other than the person who received the treatment. The rebate is determined by your individual health insurance policy. Our surgery is not responsible for any concerns you may have regarding your health fund.

DO YOU HAVE DENTAL INSURANCE? YES / NO

Health fund name…….....

Member Number:.....Serial number.....

<u>Who recommended our practice to you?</u>

O Existing patient (please name)……

O	**Doctor**	**O**	**Staff Member**
O	**Dentist**	**O**	**Yellow Pages/sensis**
O	**Beachside Dental Website**	**O**	**Passing by**
O	**Google search**	**O**	**Call Connect**
O	**Facebook**	**O**	**Leader Newspaper**
O	**Smooth FM Radio**		

MEDICAL HISTORY QUESTIONNAIRE:

Please Tick

YES	NO		DETAILS
		High Blood Pressure	
		Low Blood Pressure	
		Heart Ailment or Heart Murmur	
		Congenital heart Problem	
		Heart Valve/Pin/Stent	
		Pacemaker	
		Rheumatic Fever	
		Bleeding Disorder	
		Diabetes	
		Liver or Kidney Disease	
		Hepatitis A / B / C / D / E	
		HIV / AIDS	
		Asthma	
		Epilepsy	
		Cancer	
		Chemotherapy	
		Bone Disease / Disorder	
		Tuberculosis	
		Hormone Supplements	
		Knee / Hip / Joint Replacement	
		Ladies, are you pregnant?	Due date:

Please list any past operations: ……..…..
……

Are you currently under any medical care? YES NO
Are you currently taking any medications/drugs? If yes, please list: ……..…..
……..

Are you allergic to Penicillin? YES NO MAYBE
Are you allergic to latex? YES NO MAYBE
Please list any allergies: ……..

Have you ever reacted badly to medication? YES NO
If yes, please specify:……..…..

Have you ever reacted badly to Dental Treatment? YES NO
If yes, please specify:……..…..

DENTAL HISTORY

Do you smoke? YES NO
Does your jaw click or hurt? YES NO
Have your teeth chipped or worn down? YES NO
Do you grind your teeth? YES NO
Does food get stuck between your teeth? YES NO
Have you had previous gum problems? YES NO
Do your gums bleed when you clean your teeth? YES NO
Do you suffer from bad breath? YES NO
If there was a simple way to whiten your teeth, would you be interested?.....
If there was anything you could change about your smile, what would it be?.....
……

Who was your previous Dentist?.....
When was your last Dental Examination?.....
When were your last dental x-rays?.....

Is there anything you wish to discuss with the Dentist in private?.....

The purpose of my visit today is……..
……
Do you consent to Receiving a Dental Examination and Treatment? (Please write YES or No) ……

Signed:……Date…….…….....

BEACHSIDE COMPLETE DENTAL CARE

YOUR HEALTH INFORMATION – PRIVACY CONSENT FORM

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 it 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 regarding your treatment 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 will apply to these services.

5) If any of the information we have about you is inaccurate, you may ask to alter our records accordingly.
You can otherwise be rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person 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.

6) I hereby grant permission for the use if any illustrations, photographs or imaging records created in my case for use in scientific and professional journals and presentations at any time during or after treatment with no disclosure of any person details relating to my identity.

7) We may use a range of means to communicate with you which may include telephone, post and electronic communication such as SMS messaging and/or email. By signing this consent form I grant permission and agree to receive communication from Beachside Complete Dental Care by telephone, post, SMS messaging and email where applicable

<u>Please sign this form as confirmation that you have read and understood our privacy policy, and consent to use of your health information in this way.</u>

Signed:…….Date…….…….....

Patient/Parent/Guardian Name:……