Patient Registration and Medical History Form

Patient Details (Please Print)

Title: Mr / Mrs / Ms / Miss / Dr / Other: ______________

Given Name: ____ Surname: ________________________________

Preferred Name: __________________________ Date of Birth: ____/____/______ Gender: Female / Male

Email: ____

Phone (Home): _________________________________ Phone (Work): __________________________________

Phone (Mobile): _______________________________ Occupation: ____________________________________

Home Address: ____

Suburb: ____ Post Code: __________

Emergency Contact Name: ____________________________________ Relationship: _________________________

Contact Number/s: ____

Health Fund – We are unable to process any health insurance claims (HICAPS)

Private Health Insurance (Hospital)? Y☐ N☐ Extras (Dental)? Y☐ N☐ Provider Name: ______________

Membership Number: ____ Position Number on Card: ____

Medicare Information

Medicare? Y☐ N☐ Medicare Number: ____________________ Position Number: ____ Expiry: ___/____

Who Referred You To The Western Dental Specialist Group?

Referring Clinician Name: ____

Contact Details: ____

Medical Doctor Information

Clinic Name/Doctor Name: ____

Contact Details: ____

Consent For Services:

- I agree that the information provided on this form is a true and accurate record
- I understand that Western Dental Specialist Group requires full payment on the day of treatment
- I understand I may be charged an $50 fee if I cancel my appointment with less than 24 hours' notice. In addition, repeated non-attendance may result in a fee or deposit being paid prior to future appointments being scheduled.

Patient / Guardian Name (Please Print): ____

Signature: ***x***... Date: ____/___/______

Medical Questionnaire

Please answer all of the following questions:

If you are unsure about anything please discuss with your dental practitioner.

Question	Y/N	Question	Y/N
Have you ever stayed in hospital, had an operation or a general anaesthetic? If **YES**, please specify: ______________________	Y☐ N☐	Do you smoke? If **YES**, how many per day: __________ and for how long: __________	Y☐ N☐
Any heart complaint / condition / murmur / pace maker	Y☐ N☐	Any joint problems / arthritis / history of joint replacement surgery?	Y☐ N☐
Blood pressure: High / Low	Y☐ N☐	Tuberculosis	Y☐ N☐
Diabetes: Type I / Type II	Y☐ N☐	Liver disease / hepatitis	Y☐ N☐
Blood disorders / Prolonged Bleeding	Y☐ N☐	Thyroid disease	Y☐ N☐
Rheumatic fever	Y☐ N☐	Kidney problems	Y☐ N☐
Stroke / seizures / other neurological	Y☐ N☐	Anxiety / depression / other	Y☐ N☐
Radiation therapy / chemotherapy	Y☐ N☐	HIV / AIDS	Y☐ N☐
Asthma / bronchitis / lung conditions	Y☐ N☐	Are you a blood donor?	Y☐ N☐
Osteoporosis / bisphosphonate therapy	Y☐ N☐	*For women only:* Are you Pregnant? If **YES**, when are you due: ______________	Y☐ N☐

Question	Y/N
Do you have any allergies or had a reaction to medications or latex? If **YES**, please specify: ____	Y☐ N☐
Have you ever had any serious problems after dental treatment? If **YES**, please specify: ____	Y☐ N☐
Any other medical conditions? If **YES**, please specify: ____	Y☐ N☐
Are you currently taking any medications or tablets regularly? If **YES**, please specify below:	Y☐ N☐

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Clinician Signature:

x..

Privacy Policy and Important Information

We respect your right to privacy and we have systems in place to ensure we comply with the Australian Privacy Principles.

Our practice collects health information about you in order to provide you with dental services. Personal information collected such as your name, address, contact details, health insurance and financial details are used to address accounts to your, process payments, collect unpaid invoices via an external collection agency, and to contact you about our services and any issues affecting your health.

- We may collect your health information from other health professionals, or disclose it to them if, in our judgement, it is necessary in the context of your care.
- We may use parts of your health information for teaching and research purposes. All information collected and used will be de-identified. Please let your clinician know if you do not wish for your case to be used for research or teaching purposes.
- If you choose not to provide us with information relevant to your care, we may not be able to provide a service to you, or the service we are asked to provide may not be appropriate to your needs. Importantly, you could suffer some harm or other adverse outcome if you do not provide us with relevant information.
- We will securely store your records, such as x-rays, treatment and personal details and any other material relevant to your care.
- For administration purposes, we may rely on service providers located outside Australia. We will take reasonable steps to ensure that any offshore data transfer complies with Australian privacy laws. Whilst our practice takes all reasonable steps to ensure security of your information, we cannot guarantee secure transmission of information over the internet.

Please note that accounts are payable on the day. An administration fee will apply for unpaid accounts that have not been settled within 14 days from the time of treatment.

By signing below, you are acknowledging that you have read and understood the above information.

Patient / Guardian Name (Please Print): ____________________

Signature: ***x***.. **Date:** / /