Patient Information and Medical History

WESTERN DENTAL SPECIALIST GROUP

Personal Information

Title: *Master / Mr / Miss / Ms / Mrs / Dr / Other (please specify):* _____

Given name: _____ Surname: _____

Preferred name: _____ Date of birth: ___/___/_____

Gender: *Female / Male / Other* Pronouns: _____ Email: _____

Home address: _____

Suburb: _____ State: _____ Postcode: _____

Phone (home): _____ Phone (mobile): _____

Phone (work): _____ Occupation: _____

Emergency Contact

Emergency contact full name: _____ Relationship: _____

Contact number/s: _____

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

Do you have private health insurance (Hospital cover)? ☐ Yes ☐ No Do you have extras (Dental cover)? ☐ Yes ☐ No

Provider name: _____ Member number: _____ Position number on card: ____

Medicare Information

Do you have Medicare? ☐ Yes ☐ No Medicare number: _____ Position number: ____ Expiry: ___/_____

Referral (How did you hear about us / who referred you here?)

☐ General dentist ☐ Current or former patient ☐ Google
☐ Dental specialist ☐ Family member / friend ☐ Signage
☐ Medical doctor ☐ Word of mouth ☐ Other (please specify): _____

If applicable, please provide name: _____

General Dentist Information:

Clinician name: _____ Contact number: _____

Clinic name: _____ Suburb: _____

Medical Doctor Information:

Doctor name: _____ Contact number: _____

Clinic name: _____ Suburb: _____

Medical Information

Do you have or have you ever suffered from any of the following? Please indicate:

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

Have you ever stayed in hospital, had an operation or a general anaesthetic? If **YES**, please specify: _____	☐ Yes ☐ No	Do you smoke or have you ever been a smoker? If **YES,** how many per day: _____ and for how long: _____	☐ Yes ☐ No
Any heart complaints / condition / murmur / pacemaker	☐ Yes ☐ No	Any joint problems / arthritis / history of joint replacement surgery	☐ Yes ☐ No
Blood pressure: high / low	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes: type I / type II	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Radiation therapy / chemotherapy	☐ Yes ☐ No	Kidney problem	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Asthma / bronchitis / lung conditions	☐ Yes ☐ No
HIV / AIDS	☐ Yes ☐ No	Anxiety / depression / other	☐ Yes ☐ No
Osteoporosis / bisphosphonate therapy	☐ Yes ☐ No	Are you a blood donor?	☐ Yes ☐ No
Stroke / seizures / epilepsy / other neurological problems	☐ Yes ☐ No	Liver problems / hepatitis If **YES**, please specify: _____	☐ Yes ☐ No
Blood disorder / excessive bleeding If **YES**, please specify: _____	☐ Yes ☐ No	*For women only:* Are you pregnant If **YES**, when are you due: _____	☐ Yes ☐ No
Do you have any allergies or had a reaction to medications or latex? If **YES**, please specify: _____			☐ Yes ☐ No
Have you ever had any serious problems after dental treatment? If **YES**, please specify: _____			☐ Yes ☐ No
Any other medical conditions? If **YES**, please specify: _____			☐ Yes ☐ No
Are you currently taking any medications or tablets regularly? If **YES**, please specify below			☐ Yes ☐ No

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 you, 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 information to them if, in our judgement, it is necessary in the context of your care.
- 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.
- 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.
- 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.

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.

By signing this form, you agree to our privacy policy. Furthermore, you agree that the personal and health information you have provided herein is true and correct, to the best of your knowledge, and you understand that any failure to disclose information may be detrimental to your treatment.

In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.

Patient / Guardian Name (Please Print): _____

Signature: *x*…… **Date:** ___/___/_____