# PATIENT INFORMATION FORM

dental care Glebe

In order to provide you with the highest standard of dental care, *Dental Care Glebe* is required to collect personal details. Our practice respects your right to privacy. Our practice is bound by the **Australian Privacy Principles contained in the Commonwealth Privacy Act 1988 (Privacy Act), Health Records and Information Privacy Act 2002** and applicable State legislation. Personal information will also be used for the purpose of billing and processing payments unless consented otherwise. If you have any queries/concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Title :( ) Full Name: _____

Address:_____

_____

_____Post Code:_____

Home Phone: _____

Mobile: _____

Work: _____

Email Address: _____

How would you like to receive appointment reminder?

SMS PHONE CALL EMAIL

How would you like to receive 6-monthly check up & clean reminder?

SMS PHONECALL EMAIL POSTCARD

Date of Birth: (DD/MM/YY) _____

Occupation: _____

Parent's Name (If under 18y/o): _____

Person to Contact in case of Emergency:

Name: _____

Address: _____

_____

Phone: _____

Person Responsible for Account (if not the Patient):

Name: _____

Phone: _____

Are you a permanent resident? ☐ YES ☐ NO

If NO, VISA type _____

How did you hear about us?

☐ INTERNET ☐ WALKED BY ☐ YELLOW PAGES

☐ FAMILY / FRIENDS_____ ☐ OTHER _____

Are you satisfied with the appearance of your teeth? YES NO

Would you be prepared to take necessary steps to keep your teeth? YES NO

Do you feel nervous about having dental treatment? YES NO

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental treatment? YES NO

If yes, please describe _____

Do you suffer from any of the following, if you answered **YES** on any please circle and specify:

| | | | |
|---|---|---|---|
| Heart Condition | YES | NO | _____ |
| Heart Murmur | YES | NO | _____ |
| Mitral Valve Prolapse | YES | NO | _____ |
| Other Heart Issues (surgery/pacemaker) | | | _____ |
| Lung Problem | YES | NO | _____ |
| Kidney Problem | YES | NO | _____ |
| Diabetes | YES | NO | _____ |
| Asthma | YES | NO | _____ |
| Rheumatic fever | YES | NO | _____ |
| AIDS (HIV) | YES | NO | _____ |
| Hepatitis A, B, C | YES | NO | _____ |
| Radiation Therapy | YES | NO | _____ |
| Tumour | YES | NO | _____ |
| Blood Transfusion | YES | NO | _____ |
| Blood pressure | NORMAL | | HIGH LOW |
| Latex Allergy | YES | NO | _____ |
| Liver Disease | YES | NO | _____ |
| Chemotherapy | YES | NO | _____ |
| Tuberculosis | YES | NO | _____ |
| Haemophilia | YES | NO | _____ |
| Any artificial joint or valve? | | | _____ |
| Anxiety Disorder/Depression | YES | NO | |
| Epilepsy | YES | NO | |
| Obesity | YES | NO | |
| Osteoporosis | YES | NO | |

Peptic Ulcer YES NO

Any other serious medical condition not listed?

_____

_____

_____

Allergies (include allergies to any medications)

_____

_____

_____

Are you currently taking any medications? If **YES**, please list:_____

_____

_____

Have you ever taken Biphosphonate medication as listed below? YES NO

Fosamax ◆ Benefos ◆ Didronel ◆ Didrocal ◆ Aredia ◆ Skelid ◆ Actonel ◆ Zometa

Any recent hospitalisation? _____

Have you experienced prolonged bleeding? YES NO

Have you ever had a difficult extraction? YES NO

Are you pregnant? YES NO Trimester:_____

Name of GP / Physician: _____

**PLEASE TURN OVER AND COMPLETE OTHER SIDE OF THE FORM**

## PRACTICE POLICY

Here at Dental Care Glebe, we are committed in delivering the best possible dental care. We have outlined our practice and payment policy below and ask for your understanding and cooperation.

1. **Initial / Emergency / Single Treatment Visits** – The fee shall be indicated on invoices provided by Dental Care Glebe to the patient in respect of the services provided. Full payment is due at the time of consultation / service delivery. We accept Cash, Cheques and the following credit cards: Visa, Master Card and American Express for your convenience.
2. **Multiple Visit Treatments** – All services are provided on a fee for service basis unless other arrangements have been made with your treating dentist. Your dentist will prepare a treatment plan and quotes for your review.
3. **Insurance Rebates** – We can claim insurance rebate on the day of treatment upon presenting your health fund card. Rebates vary between health fund companies and the type of your insurance coverage. You may obtain an estimate of the insurance rebate by presenting your treatment proposal to your insurer.
4. **Overdue Accounts** – Late payment fees incur interest of 2.5% per month. If an account requires collection by a third party agency, the patient/guarantor will be responsible for any fees incurred.
5. **Bookings, Cancellation and Rescheduling Policy** – A missed appointment is a loss to three people, the patient, another patient who could have used the valuable time and the Dentist who was fully staffed and prepared for the treatment. Please be considerate and provide at least 24 hours' notice to cancel or reschedule your appointment. A fee will be charged for all missed appointments and appointments cancelled without notice.
6. Additional procedures may be required if something unexpected is encountered during your treatment. Any additional treatment and costs will be discussed with you.
7. We respect your right to privacy. The patient, at any time, may request for Dental Care Glebe Privacy Policy Statement should you have any concerns about handling your personal information.

I understand the collected information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider who may release such information to you. I will notify the dentist of any change in my health.

I hereby authorise the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make thorough diagnosis of my/my ward's dental needs. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me (the patient) and to employ such assistance as required to provide proper care.

I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

I understand that Dental Care Glebe requires payment on the day of treatment. Any expenses, costs or disbursements incurred by Dental Care Glebe in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled. I have read and agree with the Practice Policy.

**Please note:** The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

Patient: _____

Signature of Patient: _____

Date: _____

OFFICE USE ONLY:
Data entered by: Form checked by: Form scanned by: