CONFIDENTIAL INFORMATION

PERSONAL and MEDICAL HISTORY FORM (Initial visit)

Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mst ☐ Sister ☐

Last name ____________________________ **First name** ___________________ **Date of birth** ____________

Address ____ **Suburb** ____________________ **Pcode** _______

Home ☎ ____________________ **Work ☎** _______________________ **Mobile ☎** _____________________

Email _____________________________________

Occupation ______________________ Next of kin /parent / guardian ___________________________________

Medical practitioner name/address/phone____

____

Dental Health Fund __________ Card number ___________________ Member ID _____ *(number next to your name)*

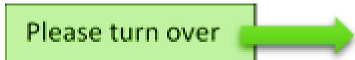
Medicare No. _____________________ Member ID ____ *(number next to your name)*

How did you find out about our practice? ____

DENTAL and MEDICAL HISTORY *Please tick and write details if it applies to you.*	
How long ago was your last dental visit?	
Have you had problems with previous dental treatment?	☐
Have you ever had a bad reaction to local anaesthetics?	☐
Do you prefer local anaesthetic?	☐
Do you prefer laughing gas (nitrous oxide sedation)?	☐

Are you or have you ever been treated for any of the following? *Please tick and write details if it applies to you.*					
Hospitalization or had a serious illness in the last 3 years?	☐	Bleeding problems, bruising easily?	☐	High blood pressure?	☐
Heart problems?	☐	Dry mouth?	☐	Hepatitis, HIV, or other liver disease?	☐
Diabetes (I or II)?	☐	Seizures?	☐	Thyroid problems?	☐
Asthma?	☐	Allergies to latex, medication, or foods?	☐	Mental illness?	☐
Regular injections e.g *Prolia*	☐	Do you have or have you had any other diseases or medical problems NOT listed on this form?	☐	Please list…	
WOMEN: Are you pregnant or breast-feeding?	☐				

Are you taking?	
Medications? Including injections	Please list …
Tobacco smoking?	How many per day?
Recreational drugs?	Please list …



OUR POLICIES

☎ 02 4625 4897

1. Financial Policy
   - Payment is requested at the time of treatment.
   - Payment plans may be available upon request (min $80pw).
   - Outstanding accounts will incur a late fee of $13 per fortnight.
   - An administrative Debt Collection fee ($100) will apply for delinquent debts.
   - I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

2. Cancelling appointments or broken appointments
   An appointment is a time reserved for you – we do not operate on a "first in, first served" basis.
   - If you are unable to attend, we ask for at least 24 hours notice of cancellation or a fee may be applied to allay our fixed running costs.
   - For Saturday appointments, if you are unable to attend, we ask for notice of cancellation by **lunchtime on the previous Thursday** or a fee may be applied to allay our fixed running costs.

3. Privacy Policy
   As changes in the Commonwealth privacy laws started on 12th March 2014, including an amendment of the Privacy Act 1988 (effective 12th March 2014) and a Privacy Amendment (Enhancing Privacy Protection) Act 2012, Family Dental Care have updated the privacy policy. The policy of our practice is to follow these procedures:

   - The information collected on this form, including any images, 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.
   - We may disclose your health information to other health care professionals, for example, your doctor or specialist, or require it from them, if in our judgement, it is necessary in the context of your treatment.
   - Your patient history, treatment records, radiographs (x-rays) and other material relevant to your treatment will be kept here. You may inspect or request copies of your treatment, records at any time, 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.
   - 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 consent.
   - Surveillance cameras are used in this surgery for training and security purposes. Please be aware that you may be under surveillance. If you appear in any images, it will in never be used for publication or the like.
   - 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.
   - If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

   - If all or part of the information is **NOT** provided to us by you on the Personal & Medical History form, subsequent Medical History Update forms or by discussing it with the dentist**, it may adversely affect your health and your treatment options.**

Your agreement

1. I agree to the terms and conditions of these policies and sign this form as confirmation that I have read and understood the financial/privacy policy and consent to the use of my health information and surveillance in this way.
2. **To the best of my knowledge, I have answered every medical question completely and accurately.**
3. **I will inform my dentist of any change in my health and/or medication.**

Name: ____________________________________ if child, name of parent/guardian______________________

Signature: ____ Date: ___________________

(Dentist's signature)________________