

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of oral health care (dental treatment). The information you provide is confidential and will be handled in accordance with our privacy policy which is shown on the second page of this form.

PERSONAL DETAILS							
First Name:		Last Name:		Title (e.g. Mr/Mrs/Ms):			
Date of birth (dd/mm/yyyy):		Phone (Home):		Mobile:			
Street Address:							
Suburb:				Postcode:			
Email:							
Emergency Contact Name (required):				Mobile:			
Medical Practitioner (Doctor):				Phone:			
I have confidential medical information that I do not wish to write down. I would prefer to speak to the dentist (tick box).							
QUESTION	NO	YES	If YES, please provide details				
Are you being treated by a doctor at present?							
Do you normally require antibiotic cover before dental treatment?							
Have you had any abnormal reactions to local or general anaesthesia?							
Do you smoke?							
Are you pregnant (females only)							
Do you have a Health Fund with Extras (Dental)? (Please specify)							
DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Please tick appropriate box)							
CONDITION	NO	YES	(If YES, please provide details)	CONDITION	NO	YES	(If YES, please provide details)
Steroid Therapy				Prosthetic/Transplanted Organ (eg artificial hip)			
Rheumatic Fever				Radiation/Chemo therapy			
Contact with HIV/AIDS virus				Osteoporosis/Bone Disease			
Hepatitis or other liver disease				High or low blood pressure			
Asthma				Excessive Bleeding/ Taking Blood Thinners			
Diabetes				Stroke			
Nervous condition				Heart Complaint/ Murmur			
Stomach or digestive condition				Heart Valve Disorder/ Cardiac Pacemaker			
Tuberculosis				Anaemia, leukaemia or other blood diseases			
Thyroid disease				Bronchitis, emphysema or other lung diseases			
Kidney Disease				Any other condition(s)			
Epilepsy				Allergies including drugs, latex and other			
Please list any tablets/medications you are currently taking:							
Please list any concerns that you have with your teeth/mouth:							
Referred By: <input type="checkbox"/> Internet Search <input type="checkbox"/> Newspaper <input type="checkbox"/> Flyer <input type="checkbox"/> Street Sign <input type="checkbox"/> Oral Health Voucher <input type="checkbox"/> You are a current patient <input type="checkbox"/> Social Media (please specify below) <input type="checkbox"/> Another person (please specify below) <input type="checkbox"/> Other (please specify below)							
I have read and accept the privacy policy and payment policy on the second page of this form.						OFFICE USE ONLY:	
Signature: _____ Date: ____/____/____						Entered	Filed
If Parent/Guardian, Please Print Name: _____							

PRIVACY POLICY

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number but it is also necessary for the dentist to obtain from you details regarding your general health and past medical and surgical events. Without this general health picture, the treating dentist is unable to plan your care properly. Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating dentist in order to deliver your care to the highest standards.
- It will not be disclosed to those not associated with your treatment without your consent except as provided under the legislation and where we consider you would have a reasonable expectation of us to provide such information.
- You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times.
- There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up to date.
- We will take reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure.
- Our staff are trained to respect these principles at all times.

PAYMENT POLICY

I verify that all details I have provided in the medical history form on the reverse is true and accurate. I confirm that if I have been unable to provide payment at the time of treatment, I will return to provide full and complete payment within five (5) business days from the date of unpaid treatment. If I fail to do this, I understand that I will be charged a minimum \$100 administrative fee, and interest on overdue invoices shall accrue daily from the date of unpaid treatment to the date of payment at a rate of three percent (3.0%) per calendar month. I indemnify Dental Aspects Pty. Ltd. from and against all costs and disbursement incurred in recovering overdue invoices (including but not limited to legal costs, collection agency costs, internal administration costs and bank dishonour fees).

If you have any questions regarding the information we collect from you and hold in your dental records, please do not hesitate to ask us. **We are acting in your interest at all times.**