

Preferred Title (please circle)      Mr      Mrs      Ms      Miss      Dr      Other \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Postal Address \_\_\_\_\_

Home Address \_\_\_\_\_

Telephone (Home/Work/Mobile) \_\_\_\_\_

Email: \_\_\_\_\_ Would you like to receive emails from us?    Yes    No

Date of Birth \_\_\_\_\_ Emergency Contact (Name &amp; Telephone) \_\_\_\_\_

Private Health Insurance \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Please be aware that **FULL payment** is required at the time of treatment. We have HICAPS for processing private health insurance claims in most situations. Please note, when claiming is not possible due to issues with your Health Fund, as per practice policy, accounts will need to be *paid in full* at your appointment. We accept Visa, MasterCard, EFTPOS and cash. AMEX transactions attract a **1% surcharge**. We do not accept private or business cheques for payment.

<b><u>Medical / Dental History</u></b>	Please tick answer <input checked="" type="checkbox"/>	<b>No</b>	<b>Yes</b>	<b>If YES please provide details:</b>
Have you ever had a serious or long-standing illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had <b>heart</b> trouble or high/low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you a diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had a transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had rheumatic fever, hyperthyroidism, asthma, glaucoma, nervous disorders or anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you any known <b>allergies</b> to any drugs, latex or medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had radiation treatment for cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you under <b>current medical treatment</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If so, please list all medications: _____				
Have you experienced prolonged bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Women, if you are pregnant, what is your expected delivery date?				General medical practitioners name: _____

## **Privacy Policy**

Please see our receptionist for our full privacy policy. We would like to assure you that:

- The treating dentist will only use this information in order to deliver your care to the highest standards.
- It will not be disclosed to those not associated with your treatment, without your express consent.
- You may seek access to the information held about you and we will provide this without undue delay. This includes copying of information or special access. We will need your signature to authorise the copying or transfer of your records.
- We will take reasonable steps to ensure that at all times the details we keep about you are accurate, complete and up to date.
- We will make reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure.
- Our team is trained to respect these principles at all times. If you have any questions please feel free to ask us.

Signature \_\_\_\_\_

*Thank You*