NEW PATIENT MEDICAL HISTORY FORM

SOUTH MORANG DENTAL

Surname ..... Title Mr / Mrs / Ms / Miss / Mast / Dr
Given name(s) ..... Date of Birth .....
Residential address ..... P/Code .....
Postal address (if different) ..... P/Code .....
Business address ..... P/Code .....
Telephone (H) ..... (W) ..... (M) .....
Email address ..... (Fax) .....
Occupation .....
Name of person responsible for fees .....
Address (if different to above) .....
Emergency contact .....
Address ..... Telephone .....
Medical doctor .....
Address ..... Telephone .....
Do you have dental insurance? Yes / No Which Fund? .....
How did you hear about this practice? .....
How would you like to receive appointment confirmations from us? Email / SMS / Telephone / None
How would you like to receive periodic examination reminders from us? Email / SMS / Mail / Telephone / None

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please Circle)

Rheumatic Fever	Yes / No	Hepatitis A / B / C	Yes / No
Epilepsy	Yes / No	High Blood Pressure	Yes / No
Asthma	Yes / No	Heart Ailment	Yes / No
Tuberculosis	Yes / No	AIDS/HIV	Yes / No
Diabetes	Yes / No	Excessive Bleeding	Yes / No
Kidney Disease	Yes / No	Thyroid Problems	Yes / No
Stomach or bowel problems	Yes / No	Do you smoke?	Yes / No

List any other previous illnesses .....
Would you like to discuss these questions in private with the dentist? Yes / No
Do you have: an artificial hip, heart valve, or other prosthetic implant? .....
Have you ever had problems with dental treatment? Yes / No If so, list: .....
Are you currently under medical care or taking any medications? Yes / No
List any medications you are currently taking .....
Do you have any allergies? Yes / No
List any medicines/products you are allergic to .....
FEMALE PATIENTS, are you pregnant? (Please indicate) Yes / No / Unsure? Weeks / Months? .....

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE

I have completed this New Patient History Sheet to the best of my knowledge & understand that failure to make full disclosure may place ME at undue medical risk. I also understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other practitioners to aid them in my treatment, & I give my permission for this to occur when necessary. I also give permission for this practice to use this information to send me appointment & check-up reminders.

Signature ..... Date ..... (P.T.O)

YOUR HEALTH INFORMATION – PRIVACY CONSENT FORM

In accordance with the Victorian Records Act 2001 & Federal Privacy Act 1988

Our practice respects the right to your privacy. We realize that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

The policy of our practice is to follow these procedures:

1. The information collected 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 our services and any issues affecting your treatment.

2. We may disclose your health information to other health professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In the event, disclosure of your personal information will be minimized wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should this happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. If any information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assure that 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 written consent. If you have any queries or concerns about the handling of your health information, please do not hesitate to raise these concerns with our practice.

Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of you health information in this way.

Signed .....

Date.....

Name Patient / Parent / Guardian.....

Patients are reminded that payment on the day of treatment is required