MEDICAL AND DENTAL HISTORY

We ask you to provide the following pre-treatment information.
The information we collect enables us to care for you better.
We value your privacy, so all details will be kept strictly confidential.

ORALMAX SURGEONS

YOUR DETAILS

Title _____ Surname _____ First Name _____

Address _____

_____ Postcode _____

Mobile Phone _____ Home Phone _____

Email _____ Date of birth _____

Do you belong to a health fund? _____ Which fund? _____ Membership # _____ Ref # _____

Medicare # _____ Ref # _____

BUSINESS CONTACT

Occupation _____ Work Phone _____ Business Name _____

Business Address _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE THIS SECTION

Mother's Full Name _____ Occupation _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Father's Full Name _____ Occupation _____

Mobile Phone _____ Home Phone _____ Work Phone _____

DENTAL INFORMATION

How did you hear about our practice? _____ Name of your general dentist? _____

Address _____ Contact # _____

When did you last visit your general dentist? _____

What is the purpose of our visit today? _____

CONFIDENTIAL HEALTH INFORMATION

Name of your general medical doctor? _____ When did you last see your doctor? _____

Have you had any significant medical problems in the last year? _____

If yes, please specify _____

PLEASE TURN OVER

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS? Please tick as appropriate

	Yes	No		Yes	No		Yes	No
Arthritis	☐	☐	Stroke or heart attack	☐	☐	Heart Trouble	☐	☐
Rheumatic Fever	☐	☐	Kidney disease	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	Epilepsy or fits of any type	☐	☐	Excessive bleeding	☐	☐
Angina	☐	☐	High blood pressure	☐	☐	Anaemia	☐	☐

Other _____

Do you have any allergies? (e.g. penicillin, codeine, nickel, latex) _____

Do you take any prescribed drugs, tablets, medicines or creams? _____

Have you ever taken or been given medication for osteopenia or osteoporosis? _____

Do you take any recreational drugs? _____

Have you had any adverse reactions to any treatments or medications? _____

If yes, please specify _____

Have you had radiation treatment to the head or neck? _____ When? _____

Do you have a heart murmur, or artificial heart valve? _____ Please specify _____

Do you have any prosthetic body parts? (e.g. artificial hip or knee joint) _____ Please specify _____

Ladies, are you pregnant or family planning? _____ If so, how many weeks? _____

Do you smoke? _____ If so, how many? _____

PAYMENT, OUR PRIVACY POLICY & HOW WE TREAT YOUR HEALTH INFORMATION

In accordance with the Victorian Health Records Act 2001 & Provacy Act 1988 (C'with) + 2012 Amendments

We respect your privacy and we believe you should know why we collect health-related personal information from you, as well understanding how this information may be used and disclosed to others.

With regard to your health-related information, we adopt the following protocol:

- We use your personal information in order to provide an effective service to you. Demographic and financial details will be used in order to address accounts, to process payments and to communicate with you about our services. Your name, address and health insurance details may be disclosed to other organizations if required by law, or for the purposes of recovering outstanding accounts.
- When required for your treatment, your information may be disclosed to other health care professionals.
- We maintain your records (including medical history and medical images) at our practice. You may request a copy of our records of your treatment, or have the doctor explain them to you. Some fees may apply for certain types of access.
- Occasionally your de-identified information, including clinical photographs may be used for research, audit or presentations to other professionals. Identifying information is not disclosed without your consent. In the context of the above, we will otherwise maintain your records confidentially and will seek your express consent before disclosing your information.
- Please feel free to raise any concerns you have regarding the privacy of your information with your surgeon or the Practice team.

I have read and understood this Privacy Policy and consent to my health related information being used as described.

Signature _____ **Date** _____

I understand that payment is required on the day of treatment. My preferred method of payment is:

Cash ☐ Cheque ☐ EFTPOS ☐ Mastercard ☐ Visa ☐

Signature _____ **Date** _____

FAILURE TO GIVE 24 HOURS NOTICE FOR APPOINTMENT CHANGES MAY INCUR A CANCELLATION FEE