Centre for Advanced Dentoalveolar Surgery

PATIENT DETAILS

Surname:		Title: Mr / Mrs / Ms / Miss / Dr / Master
Given name:	Preferred name:	Date of Birth:
Address:		Postcode:
Email address:		Occupation:
Telephone:	Mobile:	Business:
Postal address (if different to above):		
Name of person responsible for fees:		
Address (if different to above):		
Private Health Fund:		Number:
Medicare number:		Ref No:
Veteran affairs card holder: YES / NO	Card number:	
Emergency contact:		Relationship:
Address:		Contact number:
Medical Doctor:		Phone:
Dentist:		Phone:

PRIVACY POLICY

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which your personal and health information is collected, as well as how this information is used and to whom this information might be disclosed.

The policy of our practice is to follow these procedures:

- The information collected will be used for the purposed 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 issues affecting your treatment.
- We may disclose your health information to other healthcare professionals and hospitals, or request it from them if it is necessary in the context of your treatment. Disclosure of your personal details will be minimised to relevant information.
- Information may be disclosed to and requested from other people or organisations in order to finalise accounts in a timely manner.
- Your assistance is requested in providing updated personal and health information at subsequent visits, particularly regarding changes to your health and medications. When additional information is provided we will keep your records up-to-date, accurate and complete.
- Anonymous details of your health information and treatment may be used for research, study or educational purposes. Your personal identity will not be disclosed without your consent.
- Your medical history, treatment records, radiographs, photographs taken for treatment purposes and any other material relevant to your treatment will be retained in a secure manner. When no longer required, information may be destroyed in accordance with government regulations.
- We will maintain and abide by a Practice Privacy Policy that conforms to Government regulations. You may request a copy of the current Practice Privacy Policy at any time.
- You may inspect or request copies of your records at any time or seek an explanation. Statutory fees will apply in relation to the type of access you seek.
- If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your personal and 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 written consent. If you have any questions or concerns about our handling of your health information, please do not hesitate to discuss these issues with our practice staff.

Please be aware that if you have an appointment booked with us and you do not arrive, or if you cancel with less than 24 hour notice, a no show/cancellation fee may apply.

PLEASE TURN OVER

MEDICAL HISTORY

Please indicate if you have ever had any of the following:

	Y	N		Y	N
High blood pressure			Diabetes		
Heart problems or a pacemaker			Thyroid problems		
Rheumatic fever			Excessive bleeding or blood disorder		
Stroke			Cancer		
Epilepsy			AIDS/HIV		
Asthma, chest or breathing problems			Creutzfeldt-Jakob disease		
Tuberculosis			Anxiety or depression		
Hepatitis A, B, C or other liver disease			Hayfever/sinus		
Stomach or bowel problems (e.g. ulcer)			Arthritis		
Kidney disease			Osteoporosis		
Do you have an artificial valve, hip or other prosthetic implant?					
Are you, or have you, been a smoker? If so how many per day?					
Have you had any problems with general anaesthetics?					
Are you taking any drugs, medicines or tablets including vitamins/supplements?					
Do you have allergies to medicines or other products (e.g. latex)?					
Current weight			Height		
Do you take recreational drugs?					
Female patients, are you or could you be pregnant?					
Any additional information you feel we should know?					
List any other previous illnesses:					

Signed _____ Date _____

If the patient is under 18 years of age, a parent or guardian must sign and provide a daytime contact number.