Advanced Dental Centre PTY LTD

PATIENT INFORMATION FORM

(Mr, Mrs, Miss, Ms, Dr) **Name(s):** ..... **Surname:** .....

Date of birth: / / **Sex:** ☐ M ☐ F **Occupation:** .....

Address: ..... **Post Code:** .....

Telephone: Home: ..... **Work:** ..... **Mobile:** .....

Email: .....

I consent to being contacted by email and/or SMS for patient reminders and to receive information about the practice ☐YES ☐NO

Emergency Contact: Name: ..... **Phone:** .....

How did you find out about us?
☐ Referred by: .....
☐ Location i.e. walking/driving past ☐ Bupa ☐ Facebook
☐ Advert/newspaper/flyer ☐ Website ☐ Yellow pages online
☐ Other .....

Private Health Fund (Extras Cover): ..... **Member No:** .....

Medicare Card Number: ..... **Individual Reference No:** .....

GP's Name: ..... **Address:** .....

Are you taking any medications? ☐YES ☐ NO Please specify which type of medication and reason:

....

....

Are you allergic to anything? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other .....

Do you have or have ever had any of the following conditions? (*please circle***)**

1. Heart Problems YES / NO
   Please specify .....
2. Liver problems YES / NO
   Please specify .....
3. Rheumatic Fever YES / NO
4. Epilepsy YES / NO
5. Fainting YES / NO
6. Diabetes YES / NO
   Type 1 ☐ Type 2 ☐
7. Kidney trouble YES / NO
   Please specify .....
8. Do you have a Pacemaker? YES / NO
   When was it placed .....
9. Asthma YES / NO
   Do you carry an inhaler? YES / NO
   Have you been in hospital within the last 12 months due to asthma YES / NO
10. Hepatitis YES / NO
    A ☐ B ☐ C ☐ Other .....
11. Do you have HIV / AIDS YES / NO
12. Lung disease YES / NO
    Please specify .....
13. Cancer What type ..... YES / NO
    Last treatment of Radiation/Chemotherapy .....
14. Females - are you currently pregnant YES / NO
    How many weeks/months? .....
15. Have you had any joint replacements? YES / NO
    When were they placed .....
16. Do you have any blood disorders such as anaemia? YES / NO
    Please specify .....
17. High Blood Pressure YES / NO

Do you have any disease, condition, or problem not listed above? (e.g. Malignant Hyperthermia) YES/NO

Please specify .....

Do you smoke? YES / NO How many per day? .....

Do you require antibiotic cover for dental treatment? (e.g. joint replacement or heart condition) YES / NO

Advanced Dental Centre Pty Ltd requires payment of your account in full at the time of treatment.
Advanced Dental Centre Pty Ltd may charge an appointment cancellation fee if 24 hours notice is not given.
As I am seeking private treatment, I understand that payment of the account is my responsibility. I undertake to pay any additional expenses incurred in recovering overdue accounts. (If patient under 16 years, person financially responsible to sign below).

Name: ..... **Signature:** ..... **Date** / /

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PATIENT DENTAL QUESTIONNAIRE

What is the main purpose of your visit today?

_____

Do you have any concerns or fears about previous dental care?

_____

Are you concerned about or experiencing any of the following dental problems?
(Please tick as many as it applies)

□ Sensitivity to hot or cold
□ Staining of your teeth
□ Bleeding gums
□ Food trapping between teeth
□ Discoloured fillings / teeth
□ Bad breath
□ Head / Neck Aches
□ Grinding / clenching of your teeth
□ Clicking/pain in the jaw joints
□ Roughness of existing fillings
□ Sensitivity when eating / drinking
□ Existing crowns / bridges / dentures

Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely

Have you ever had or require the following for dental treatment?
□ Gas (Nitrous oxide-laughing gas) □ Intravenous sedation □ General Anaesthesia

When was the last time you saw a dentist for a checkup? _____

Name of previous dental clinic _____ Dentist _____

Are you aware of grinding or clenching your teeth? YES NO

Do you suffer from headaches? YES NO

Are you happy with your smile? YES NO
If not, what do you not like about your smile?
□ Colour □ Crowding □ Not straight □ Missing teeth □ Gaps Other_____

Would you like to discuss enhancing your smile? YES NO

Have you had any Orthodontic treatments (braces, Invisalign) YES NO

Are you interested in replacing missing teeth? YES NO

Have you ever seen a hygienist/therapist for a clean? YES NO

Which toothpaste are you currently using? _____

How often do you brush? □ Once daily □ Twice daily Other _____

Do you floss? YES NO
If yes, how often? _____

Is your toothbrush □ Soft □ Medium □ Hard

Do you use a mouth rinse regularly? YES NO
If so, what type _____
Do you wear removable dentures? YES NO
If yes, when were they made? _____

Are you using any other dental device e.g. retainer, snoring appliance etc.

_____

Do you snore? YES NO

Have you had a sleep study? YES NO

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PRIVACY POLICY

Our commitment to privacy
Our practice is committed to safeguarding the personal information of patients and staff in line with our obligations under Commonwealth legislation as well as guidelines set by industry regulatory bodies such as the Australian Dental Board.[1]

What information do we collect about patients and why?

Administrative data
Our practice collects administrative data for accounting purposes, including *name, phone number, contact address/billing address, private health care fund and number, Medicare number* (if required for government-sponsored programs), *financial records of accounts and payments* (kept for five years, as required by the Australian Taxation Office), *insurance claims records, work related injuries* (records kept for five years as required under WHS legislation), *complaints*.

Dental records
We keep detailed dental records including *drug sensitivities, diagnostic tests, examination history, treatment, advice, referrals, communications with laboratories and other practitioners, x-rays etc*. to help us provide appropriate ongoing care. We may obtain this information from other practitioners or we may share this information with other practitioners with your consent as part of this ongoing care. Personal details are verified regularly and treatment records are updated at every consultation. We may add a note to health records retrospectively but we do not change records. For a detailed list of documentation please ask for a copy of **Appendix 1**.

Who else may see the information?
We may use patient information to discuss treatment with other practitioners. We may use it in a de-identified form for academic purposes, or with insurance officers or lawyers where the treatment relates to an Insurance claim or complaint.

Health Identifiers
The practice will not adopt, use or disclose an identifier assigned by any government agency except health care identifiers for purposes permitted under the *Healthcare Identifiers Act (2010) (Cwth)*.

Access and correction
Patients and staff may request access to their information or make changes to their information at any time except where we consider there is a sound reason under the Privacy Act or other legislation. We may charge to recover costs in providing access to electronic or paper records. We aim to use accurate, current and complete information and we will make reasonable attempts to correct inaccurate information or dispose of any unsolicited information or information no longer required.

Anonymity
You may provide a pseudonym for emergency treatment if it is paid in full at the time of treatment. However, anonymous treatment is not practical for ongoing care or if other practitioners or diagnostic records are required, or for Medicare funded/insurance-funded services. We may also refuse to provide anonymous treatment if it is impractical due to our legal requirements to report child abuse or to manage substance abuse.

How safe is your information?
Our practice takes all reasonable steps to protect your personal information from misuse, interference and loss and from unauthorised access, modification or disclosure. For our privacy policy in relation to IT and web site privacy, please ask for a copy of **Appendix 2**.

Complaints
If you have a complaint about the way in which your information is handled contact the Practice Privacy Officer: Dr Karl Scarpin , (08) 8297 4777. Contact the Privacy Commissioner if you are not satisfied with the response after 30 (thirty) days at http://oaic.gov.au/privacy/making-a-privacy-complaint.

Please sign to agree to our privacy policy and to receive SMS messages and/or emails for appointment reminders and to receive information about the practice.

Patient Name …… **Signature** …… **Date** / /

[1] The State Government has Information Privacy Principles, administered by the Privacy Committee, which apply to all government agencies but not to private health practices. We also observe the Australian Health Practitioner Regulatory Agency (AHPRA's) Social Media Policy (March 2014).