WHITES ROAD DENTAL CLINIC

Dental Practice QIP Quality Innovation Performance ACCREDITED

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PATIENT INFORMATION

Welcome to Whites Road Dental Clinic. In our endeavor to provide you with exceptional service, we would ask that you take some time to answer the following questions.

PLEASE COMPLETE ALL SECTIONS

Date:_____/_____/_____

Surname:_____**Mr/Mrs/Ms/Miss/Mst/Dr**

First Name:_____**Prefers:**_____**Date of Birth:**_____

Residential Address:_____

_____

Postal Address:_____

_____

Home Phone:_____**Work:**_____**Mobile:**_____

Email Address: (Please write in capital letters)_____

Name of Health Fund:_____ **Member number:**_____**Patient Number:**_____

What form of payment will be used for your treatment? PLEASE CIRCLE BELOW.

CASH or CREDIT CARD/EFTPOS

Occupation:_____

Emergency Contact Name:_____**Number:**_____

At WHITES ROAD DENTAL CLINIC as a courtesy, we offer a recall system. When you are due for your regular 6 monthly preventive care (Exam, clean & polish), we will send you a reminder via EMAIL or SMS. Please nominate how you would prefer to be reminded.

EMAIL:_____ **SMS:**_____

Would you like to receive dental awareness emails? (Please circle) YES NO

When did you last see a dentist?_____

If you are a new patient, how did you come to choose our practice?_____

Would you like to participate in patient feedback survey? (Please circle) YES NO

*******PLEASE TURN OVER THE PAGE*******

MEDICAL HISTORY

Some Health conditions and medications may require additional attention from your treating dentist. We appreciate your cooperation. All information is strictly confidential and stored in a secure manner on the premises.

Do you or have you suffered from any of the following: (circle which is appropriate)

HIGH BLOOD PRESSURE **Y N**

HEART CONDITIONS **Y N** **(Do you require antibiotic cover prior to treatment) Y N**
If yes what condition? _____

RHEUMATIC FEVER **Y N**

ALLERGIES TO MEDICATION **Y N** **If yes what medication**_____

LATEX ALLERGY **Y N**

EPILEPSY **Y N**

DIABETES **Y N** **INSULIN, TABLET, DIET (Please Circle)**
Is it under control as of this moment?_____

BLEEDING DISORDERS **Y N**

ASTHMA **Y N**

OVERACTIVE THYROID **Y N**

OSTEOPOROSIS **Y N**

REACTIONS TO LOCAL ANAESTHETIC **Y N**

HISTORY OF DIFFICULT EXTRACTIONS **Y N**

HEPATITIS A, B, C (Please circle) **Y N**

HIV (Aids) **Y N**

ANY OTHER CONDITIONS?_____

CURRENT MEDICATIONS_____

ARE YOU A SMOKER? **Y N** **how many per day?**_____

FOR FEMALES: ARE YOU PREGNANT? **Y N** **how many weeks**_____

Thank you for your time in completing this information. Whites Road Dental Clinic operates in accordance with and is bound by the National Privacy Principles under the Privacy Act 1988(NPP'S). The NPP'S govern the ways that we collect information from you that is necessary for us to attend to your dental health needs. The NPP'S also govern the way that we store this information, how we use that information and how you may have access to your dental records. The Dentist and staff at this practice have an ethical obligation to keep this information secret and guarantee confidentiality

It is important that you keep us fully informed of matters affecting your dental or general state of health, irrespective of whether they are of a temporary nature,(such as changes in current medications) or of a more permanent nature. If you fail to provide us with any relevant health or other information this may have a detrimental effect on the level of dental health care that we are able to provide. If you have any queries or concerns, please do not hesitate to speak with one of our Patient Coordinators. Thank you

I agree to pay all costs related to recovery of overdue accounts, including debt collection, solicitor and legal fees. We may charge a cancellation fee if appointments are broken without 24 hours notice.

SIGNATURE:_____ **DATE:**_____

TERMS & CONDTIONS

CONSENT TO TREATMENT, ACCOUNTS & FINANCIAL ARRANGEMENTS

CONSENT TO TREATMENT

1. I authorise the Dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis.
2. I authorise the Dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistances required to provide care.
3. I agree to the use of anesthetics, sedation or other medications as necessary.
4. I understand that using anesthetic agents embodies certain risks.
5. I understand that I can ask for a complete list of any complications.
6. I understand that it is my responsibility to alert the Dentist and staff of any health problems I have at the time of consultation and/or any medications I may be taking at the time of consultation.
7. I understand that it is my responsibility to notify the Dentist and staff to any changes to my personal information.

ACCOUNTS & PAYMENT PLANS

1. Accounts are payable on the day of treatment unless otherwise discussed with the Dentist or the practice manager.
2. Patients with extensive treatment may be eligible for a payment plan with Denticare. Conditions apply. Please ask our staff for further details.
3. Missed appointments and cancellations without 24 hours notice will incur a fee.

EMAIL & SOCIAL MEDIA

1. We will send dental awareness and patient education emails if you have opted for it. However if you have received it accidentally you can unsubscribe from the bottom of the email.
2. Please like our Facebook page for regular promotions and patient education.

FEEDBACK

1. If you wish to give us feedback by doing a feedback survey please speak with the receptionist. All feedback will be presented as anonymous.

PLEASE NOTE:
When signing the patient registration form you are agreeing to all the TERMS & CONDITIONS listed in this information sheet