KEILOR DOWNS DENTAL CLINIC
2 Medina Rd, Keilor Downs 3038
P. 9366 8130 F. 9364 1225

PATIENT INFORMATION

Name: Miss/Ms/Mrs/Mast/Mr _____ D.O.B _____/_____/_____

Address: _____ Postcode _____

Phone (Home): _____ (Work): _____ (Mobile): _____

Emergency contact name: _____ Phone Number: _____ Relationship: _____

Name of Doctor: _____ Medical Practice: _____ Phone Number: _____

Would you like your appointment confirmed by SMS? Yes ☐ No ☐
Do you have Private Health Insurance with extras (Dental)? Yes ☐ No ☐
If yes, please list Fund: _____ Please list the number on the card next to your name _____

Who recommend you to this practice: _____

HEALTH INFORMATION

Please **CIRCLE** any of the relevant medical conditions

AIDS / HIV / Hepatitis A, B or C	Cancer / Radiation therapy / Chemotherapy	Tumors	Asthma / Tuberculosis / Respiratory problems	Indigestion / Reflux / Stomach Ulcers
Allergies:	Diabetes Type: 1 2	Artificial Heart Valve / Heart Stent /Pace Maker	Stroke	Sinus Problems / Mouth Ulcers / Cold Sores
Anxiety / Depression / Psychosis / Other Mental Disorders	Epilepsy / Fainting	High Blood Pressure / High Cholesterol	Recreational Drugs:	Smoke / Ex-smoker Number per day: Duration:
Anemia /Blood diseases / Bleeding disorders	Food Intolerances:	Heart Conditions?	Operations?	Pregnant Number of weeks:
Arthritis / Artificial joint(s) Osteoporosis / Bone disease	Sleep Apnea	Liver Disease / Kidney Disease	Thyroid Disorders?	Other:
Previous / Current Injections for Osteoporosis	Head Injuries	Muscle /Nerve disorders	Rheumatic Fever	

Please list any **prescribed and non-prescribed medications**

Are you, or do you believe that you may be in a high risk category with respect to HIV or hepatitis? No ☐ Yes ☐
Are you happy with the **color** of your teeth? No ☐ Yes ☐
Have you ever had any complications following dental treatment? No ☐ Yes ☐
►Please explain: _____

Have you been admitted to hospital or needed emergency care during the past two years? No ☐ Yes ☐
►Please explain: _____

To the best of my Knowledge, all of the proceeding answers and information provided are true and correct.

If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I have read and understood the privacy policy (overleaf) and consent to the use of my health information as outlined in the policy.

I understand that payment is required on the day of treatment.

Signature of Patient, Parent or Guardian …….. *Date* ___/___/___ **P.T.O**

Your Health Information - Privacy Consent Form

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

Our practice respects your right to privacy. We realise 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 care professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised 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 that happen, your personal identity will not be disclosed without your consent to do so.

4 Your medical history, treatment records, x-rays and any 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 the 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 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 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 queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.