RED HILL
DENTAL PRACTICE

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DR. CHRIS WOOLDRIDGE
DR. PAUL GLEESON
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SKYE GREENHILL

PATIENT DETAILS

Title:__________ First name:______________________ Surname name:____________________ Date of birth:__________

Residential address:________________________________ Suburb:_______________________ Postcode:____________

Email address:____ Contact number:________________________________

Emergency contact name:__________________________________ Emergency contact number:_____________________

Doctor's name:______________________________________ Doctor's clinic number:______________________________

Private health fund name for dental insurance:___________________ Membership number:________________________

Reference number (number next to your name on card):________________

Are you eligible for the Child Dental Benefits Schedule(CDBS)? Yes ☐ No ☐

Medicare card number:__________________________ Reference number (number next to your name on card):______

Name of person responsible for fees if not self:____

Parent/guardian name(if applicable):______________________Carer name(if applicable):_______________________

MEDICAL HISTORY DETAILS

Do you suffer from any of the following allergies or health problems?

Please tick each relevant box	Yes	No		Yes	No
Are you allergic to penicillin			Stroke		
Are you allergic to local anaesthetic			Arthritis		
Are you allergic to latex			Pacemaker		
Are you allergic to any medications			Sinus trouble		
If yes please state which _________________________			Any artificial joint		
Heart problems			Please state if yes___________________		
Prosthetic implant			Epilepsy/Seizures		
Respiratory issues			Back or neck problems		
High blood pressure			Osteoporosis		
Low blood pressure			Asthma		
Diabetes If yes what type?_________			Liver or Kidney problems		
Lung disease			AIDS or HIV If yes what type?_________		
Neurological (nerve) problems			Circulatory problems		
Cancer If yes where?_________________			Thyroid problem		
Rheumatic fever			Excessive bleeding		
Tuberculosis			Hepatitis? If yes what type ______		
Anemia or other blood problems					

Please list any other relevant medical history____________________

Please list any other allergies ____________________

Please state any major surgery you have had in the last five years ____________________

Are you pregnant? If yes, how many weeks? ____________

Is there anything you would like to discuss in private?____________

Do you feel anxious about your dental appointment?____________

MEDICATIONS

There are many medications that may impact your oral health or the treatment we plan for you.

Please indicate any medications that you are currently taking or have taken recently (including natural therapies).

Alternatively a list from your GP can be attached.

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Are you on any blood thinners such as Warfarin or Aspirin?____________________

Consent to Treatment

I hereby authorise the applicable clinician or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the applicable clinician to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorise the applicable clinician to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Your Privacy

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: 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 adding accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment. We may disclose your health information to other health 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. We may also use parts of your health information for research purpose, in study groups or seminars as this may provide benefit to other patients.

Should this happen, your personal identity will not be disclosed without your consent to do so. Your medical history, treatment records, x-rays or any other material relevant to your treatment will be kept at the practice. You are welcome to inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees may apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our standard fees may apply to these services If any information we have about you is inaccurate, you may ask us to alter our records accordingly. You can otherwise rest assured 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 the practice, without your prior written consent. If you have any queries or concerns about the handling of your health information, please do no hesitate to raise these concerns with our practice.

Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Patient Name:____________________

Patient Signature:____________________

Parent/guardian name (if applicable):____________________

Parent/guardian signature (if applicable):____________________

Date:____________