Previous New Patient History

Previous Patient Information (under 5 years)

First name* | Middle name

Last name* | Preferred name*

Date of birth* | Gender* ○ Male ○ Female ○ Non-binary

Address*

Postcode* | Home phone

Mobile phone | Work phone

Email*

Family Dentist

Medical Practitioner

Medicare Number* | Expiry date* | Ref number

Medical history

This may affect your orthodontic treatment. Please mark the correct answer and provide details when necessary.

Allergy to latex*
☐ Yes ☐ No

Heart or Kidney Disease*
☐ Yes ☐ No

Allergies*
☐ Yes ☐ No

Blood pressure*
☐ Yes ☐ No

Psychiatric Illness*
☐ Yes ☐ No

Prolonged bleeding after injury*
☐ Yes ☐ No

Are you taking any medication*
☐ Yes ☐ No

Is there a possibility that you could be pregnant*
☐ Yes ☐ No

Congenital heart disease or rheumumatic fever*
☐ Yes ☐ No

Asperger's, Autism, ADD, ADHD*
☐ Yes ☐ No

Asthma*
☐ Yes ☐ No

Anesthesia complications*
☐ Yes ☐ No

Diabetes, Epilepsy, Goitre etc*
☐ Yes ☐ No

Serious operation*
☐ Yes ☐ No

Hepatitis or HIV*
☐ Yes ☐ No

Do you require antibiotic cover for dental procedures*
☐ Yes ☐ No

☐ Other

Trauma

Please mark the correct answer. If yes, please provide details

Have you ever had an accident involving teeth or jaw? *	☐ Yes	☐ No
Have you ever had clicking, noises, or pain in your jaw joints? *	☐ Yes	☐ No

Account Responsibility

To be completed by the Parent / Guardian / Responsible Party). If you are over the age of 18 years and are taking care of the account please write SELF in first name and sign.

Title	First Name
Last Name	Relationship to Client
Are the contact details above the same for the client	☐ Yes ☐ No
If no, please specify	Date

YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY - Our practice respects your right to privacy. It is important that you understand the purpose for which we collect details about you and your health, as well as how this information is used at our practice and to whom this information might be disclosed.

More detailed information is set out in our Privacy Policy. If you would like a copy of the policy please ask our staff.

The information we collect will be used for the purpose of providing treatment to you. Personal information such as your name, address, telephone numbers, email address and health insurance details will also be used for the purpose of billing and processing payments. Unless you tell us you do not want to receive information from us, we will also use these details to keep you updated about our services and advise you of other products and services relevant to your dental and general health.

Unless required to do so by court order or other legislative requirement, we will only collect, use and disclose your health information for the purposes of assessing, advising and treating you. We may also use parts of your health information for staff training, professional development, quality improvement and dental health research. Your personal identity will not be disclosed without your consent to do so or, if this is not possible, with the approval of an ethics committee.

Your patient history, treatment records, x-rays and any other material relevant to your treatment are kept in both a written form and in electronic clinical information systems.

We have security measures in place to protect this information against unauthorised access or use and damage, theft or other loss. We may use contracted external providers to assist us with this data storage, access and use. These providers are based in Australia.

You may inspect or request copies of your treatment records at any time, or seek an explanation from the Orthodontist. If you want copies, a fee may apply. If you require a detailed explanation of your records or a written summary, a consultation fee or other charge may apply.

It is important that the information we hold about you remains accurate. Please advise our staff if your contact or medical details ever change.

If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.
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.

Date* _____ Please sign here: _____