PATIENT INFORMATION FORM

dental care Glebe

In order to provide you with the highest standard of dental care, *Dental Care Glebe* is required to collect personal details. Our practice respects your right to privacy. Personal information will also be used for the purpose of billing and processing payments unless consented otherwise. If you have any queries/concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Title :( ) Full Name: _____

Address:_____

_____

_____Post Code:_____

Home Phone: _____

Mobile: _____

Work: _____

Email Address: _____

Date of Birth: (DD/MM/YY) _____

Occupation: _____

Parent's Name (If under 18y/o): _____

Person to Contact in case of Emergency:

Name: _____

Address: _____

_____

Phone: _____

How would you like to receive appointment reminder?

SMS PHONE CALL EMAIL

How would you like to receive 6-monthly check up & clean reminder?

SMS PHONECALL EMAIL POSTCARD

Person Responsible for Account (if not the Patient):

Name: _____

Relationship to Patient: _____

Phone: _____

Are you satisfied with the appearance of your teeth? YES NO

Would you be prepared to take necessary steps to keep your teeth? YES NO

Do you feel nervous about having dental treatment? YES NO

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental treatment? YES NO

If yes, please describe _____

Who referred you to this surgery? _____

Do you suffer from any of the following, if you answered **YES** on any please circle and specify:

Heart Condition	YES	NO	_____
Heart Murmur	YES	NO	_____
Mitral Valve Prolapse	YES	NO	_____
Other Heart Issues (surgery/pacemaker)			_____
Lung Problem	YES	NO	_____
Kidney Problem	YES	NO	_____
Diabetes	YES	NO	_____
Asthma	YES	NO	_____
Rheumatic fever	YES	NO	_____
AIDS (HIV)	YES	NO	_____
Hepatitis	YES	NO	_____
Radiation Therapy	YES	NO	_____
Tumour	YES	NO	_____
Blood Transfusion	YES	NO	_____
Blood pressure	NORMAL		HIGH LOW
Latex Allergy	YES	NO	_____
Liver Disease	YES	NO	_____
Chemotherapy	YES	NO	_____
Tuberculosis	YES	NO	_____
Haemophilia	YES	NO	_____
Any artificial joint or valve?			_____
Anxiety Disorder/Depression		YES	NO
Epilepsy		YES	NO
Obesity		YES	NO
Osteoporosis		YES	NO
Peptic Ulcer		YES	NO

Any other serious medical condition not listed?

_____

_____

_____

Allergies (include allergies to any medications)

_____

_____

_____

Are you currently taking any medications? If **YES**, please list:_____

_____

_____

Have you ever taken Biphosphonate medication as listed below? YES NO

Fosamax ◆ Benefos ◆ Didronel ◆ Didrocal ◆ Aredia ◆ Skelid ◆ Actonel ◆ Zometa

Any recent hospitalisation? _____

Have you experienced prolonged bleeding? YES NO

Have you ever had a difficult extraction? YES NO

Are you pregnant? YES NO Trimester:_____

Name of GP / Physician: _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE OF THE FORM

PARENT / GUARDIAN DECLARATION

I understand the above information is necessary to provide me /_____ ("my ward") with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

I hereby authorise the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make thorough diagnosis of/my ward's dental needs. Upon such diagnosis, I authorize the dentist 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 complete recital of any possible complications.

PAYMENT TERMS AND CONDITIONS

1. Definitions

1.1 "Dental Care Glebe" means Dental Care Glebe Administration Pty Ltd, its successors and assigns or any person acting on behalf of and with the authority of Dental Care Glebe Administration Pty Ltd.

1.2 "Patient" shall mean the Patient (or any person acting on behalf of and with the authority of the Patient) as described on any quotation, work authorisation or other form as provided by the Dentist to the Patient.

2. Fee and Payment

2.1 The Fee shall be as indicated on invoices provided by Dental Care Glebe to the Patient in respect of the Goods/Services supplied.

2.2 Time for payment for the Goods/Services shall be of the essence and will be stated on the invoice, quotation, or any other order forms. If no time is stated then payment will be due seven (7) days following the date of the invoice.

3. Privacy Act 1988 & Health Records and Information Privacy Act 2002

3.1 The Patient agrees for Dental Care Glebe to obtain from a credit reporting body (CRB) a credit report containing personal credit information (e.g. name, address, D.O.B, occupation, previous credit applications, credit history) about the Patient in relation to credit provided by Dental Care Glebe.

3.2 The Patient agree that Dental Care Glebe may exchange information about the Patient with those credit providers and with related body corporates for the following purposes:

(a) to assess an application by the Patient; and/or
(b) to notify other credit providers of a default by the Patient; and/or
(c) to exchange information with other credit providers as to the status of this credit account, where the Patient are in default with other credit providers; and/or
(d) To assess the creditworthiness of the Patient including the Patient's repayment history in the preceding two years.

3.3 The Patient consent to Dental Care Glebe being given a consumer credit report to collect overdue payment on commercial credit.

3.4 The Patient agrees that personal credit information provided may be used and retained by Dental Care Glebe for the following purposes (and for other agreed purposes or required by):

(a) the provision of Goods; and/or
(b) analysing, verifying and/or checking the Patient's credit, payment and/or status in relation to the provision of Goods; and/or
(c) processing of any payment instructions, direct debit facilities and/or credit facilities requested by the Patient; and/or
(d) Enabling the collection of amounts outstanding in relation to the Goods.

3.5 Dental Care Glebe may give information about the Patient to a CRB for the following purposes:

(a) to obtain a consumer credit report;
(b) Allow the CRB to create or maintain a credit information file about the Patient including credit history.

4. Default & Consequences of Default

4.1 If the Patient owes Dental Care Glebe any money the Patient shall indemnify Dental Care Glebe from and against all costs and disbursements incurred by Dental Care Glebe in recovering the debt (including but not limited to internal administration fees, legal costs on a solicitor and own client basis, Dental Care Glebe's contract default fee, and bank dishonour fees).

4.2 THE PATIENT UNDERSTANDS AND AGREE THAT IF SHE/HE FAILS TO ATTEND AN APPOINTMENT WITHOUT GIVING 24 HOURS NOTICE THAT SHE/HE WILL BE CHARGED A FAILURE TO ATTEND FEE.

4.3 By signing this Agreement you undertake to pay this account in full o or before the due date. In default of such prompt payment, you undertake to pay late payment fees of 2.5% per month on any amount outstanding and to indemnify us and pay all costs and expenses on a solicitor and own client basis if legal action is necessary, and/or any collection agency's fees, which may incur in recovering from you and overdue amount.

I certify that the above information is true and correct. I have read and understand the DECLARATION and PAYMENT TERMS AND CONDITIONS (above) of Dental Care Glebe Administration Pty Ltd which form part of, and are intended to be read in conjunction with this Patient Information Form and agree to be bound by those conditions. I authorise the use of my personal information as detailed in the Privacy Act clause therein

If the patient is not responsible for payment of accounts, then the person named below agrees to guarantee payment.

SIGNED (PATIENT/GUARDIAN): _____

FULL NAME: _____DATE:_____