Whittlesea Family Dental Pty. Ltd. ACN 159 649 377
Shop 1, 81 Church Street, Whittlesea 3757, Telephone: (03) 9716 0333 Facsimile: (03) 9716 0322

TITLE: ..... **GIVEN NAME**: ..... **SURNAME**: .....

DATE OF BIRTH ...../...../ .....

PHONE (MOB): ..... **PHONE (W):** .....

EMAIL: ..... **PHONE (H):** .....

ADDRESS: .....

EMERGENCY CONTACT NAME:.....**CONTACT NUMBER:**.....
Emergency contacts relationship to you: .....

Language spoken at home: ..... **Are you Aboriginal or Torres strait Islander: Yes or No?**

OCCUPATION: ..... **EMPLOYER:** .....

MEDICAL GENERAL PRACTITIONER: ..... **PH:** .....

HEALTH FUND: YES / NO **FUND NAME:** .....
How did you find out about us? .....

DO YOU CURRENTLY SUFFER FROM OR HAVE YOU EVER SUFFERED FROM ONE OF THE FOLLOWING?
(Please circle Yes or No and add any appropriate information)

Heart disorder	YES	NO
Rheumatic Fever	YES	NO
High blood pressure	YES	NO
Asthma	YES	NO
Another lung disorder	YES	NO
Diabetes - Please Circle One: Type 1 or Type 2	YES	NO
Hip or knee replacement	YES	NO
Do you have a physical impairment?	YES	NO
Epilepsy	YES	NO
Bleeding disorder	YES	NO
Arthritis	YES	NO
Osteoporosis	YES	NO

If yes, have you ever taken or are you taking **Fosamax/Actonel/Prolia,** Please Specify.....

Thyroid disorder	YES	NO
Cancer	YES	NO
Hepatitis, if yes, which Type: **A, B** or **C?**	YES	NO
HIV	YES	NO
Any Other serious illness – if **YES** Please Specify?	YES	NO
Do you have any allergies?	YES	NO

If yes, please specify: .....

Are you taking any medications or drugs of addiction? YES NO

If so, please specify the medications: .....

Females, are you pregnant? YES / NO If yes, Due Date: .....

Do you presently or have you ever smoked? YES / NO

If yes, year started ..... year stopped (if applicable) .....number of cigarettes /day.....

Please Sign: ..... **Date:** .....

Please read over page.

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.

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.

Signed: _____

Date: _____

Patient or Parent / Guardian Name: _____

Child or Dependants Name: _____