



**BEACHES DENTAL**  
MONA VALE

**PATIENT INFORMATION FORM**

SURNAME: ..... GIVEN NAMES: .....

Title: Dr/Mr/Master/Mrs/Ms/Miss DATE OF BIRTH: .....

ADDRESS: .....

..... POSTCODE: .....

PHONE: ..... MOBILE: .....

EMAIL: .....

OCCUPATION: .....

EMERGENCY CONTACT: .....

EMERGENCY CONTACT PHONE: .....

DO YOU HAVE DENTAL HEALTHFUND COVER:  Yes  No

HEALTHFUND: ..... MEMBERSHIP NO.: .....

DO YOU HAVE A VETRANS AFFAIRS CARD:  Yes  No IF YES:  White  Gold

NAME OF CURRENT DOCTOR: .....

DOCTOR'S PRACTICE AND PHONE: .....

HOW DID YOU HEAR ABOUT US?

- Doctor  Internet Search  Location  Friend or Family

HOW LONG SINCE YOUR LAST VISIT TO THE DENTIST: .....

HOW DO YOU RATE YOUR DENTAL HEALTH:

- Excellent  Good  Fair  Poor

ALL INFORMATION COLLECTED IS CONFIDENTIAL AND USED ONLY FOR YOUR DENTAL CARE

**MEDICAL HISTORY**

DO YOU HAVE ANY ALLERGIES? (eg: Latex, penicillin etc)  Yes  No

If yes please list .....

ARE UNDER THE CARE OF A DOCTOR CURRENTLY?  Yes  No

If yes please list conditions .....

HAVE YOU BEEN HOSPITALISED IN THE LAST 2 YEARS?  Yes  No

DO YOU HAVE A HEART CONDITION?  Yes  No

If yes please list .....

HAVE YOU EVER BLEED EXCESSIVELY REQUIRING TREATMENT?  Yes  No

ARE YOU PREGNANT OR BREASTFEEDING?  Yes  No

DO YOU GET SHORT OF BREATH LYING DOWN?  Yes  No

HAVE YOU EVER HAD BISPSPHENATES (eg: Actenol, Fosamax etc)  
OR MONOCLONAL ANTIBODIES (eg: Prolia, Xgeva etc)  Yes  No

DO YOU TAKE ANY MEDICATIONS  Yes  No

If yes please list .....

PLEASE TICK IF YOU HAVE OR HAVE HAD ANY BELOW MEDICAL CONDITIONS

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart attack                 | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Heart disease                | <input type="checkbox"/> COPD                | <input type="checkbox"/> Chemotherapy         |
| <input type="checkbox"/> Heart murmur                 | <input type="checkbox"/> Sinusitis           | <input type="checkbox"/> Radiation            |
| <input type="checkbox"/> Heart valve replacement      | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Immune suppression   |
| <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Sleep apnoea        | <input type="checkbox"/> Organ transplant     |
| <input type="checkbox"/> Angina/Chest pains           | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Joint Replacement    |
| <input type="checkbox"/> Palpations                   | <input type="checkbox"/> Smoker              | <input type="checkbox"/> Mental Illness       |
| <input type="checkbox"/> Ant-coagulant (eg: Warfarin) | <input type="checkbox"/> Endocrine disease   | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Low blood pressure           | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Steroid therapy      |
| <input type="checkbox"/> High cholesterol             | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Human growth hormone |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Reflux              | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Bleeding disorder            | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Anaemia                      | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> HIV                  |

ANY ILLNESS NOT LIST ABOVE .....

*I believe the above information to be true & correct*

SIGNED: ..... DATE: .....



# BEACHES DENTAL MONA VALE

As well as being an important professional commitment to you, our practice is required to comply with applicable Commonwealth, State and Territory privacy laws. As a part of our commitment to providing quality dental care to you, we need to collect, record and retain information about you, your health and our advice and treatment provided to you.

This information will include:

- personal details (including your name, address, date of birth, your contact details and details for next of kin and your health fund membership or other insurer where relevant).
- Your Medicare card number, your Medicare issued individual health identifier and whether you have a personal electronic health record.
- Your dental history and other relevant health information.
- Notes made during the course of dental consultations.
- X-rays, images and other electronic records of your dental health and treatments provided
- Referrals to and from other dental service providers and specialists
- Results and reports received from other dental and health service providers

Generally, we will collect this information directly from you (and where required for your dental care, your family members or carer) or from your oral health professionals and health services who have been treating you. We may need to contact your health fund or other insurer to confirm your insurance coverage. We may collect this information through a variety of ways including completing of forms, telephone, email, SMS or fax. You may also provide this information to us through our website, an ipad or tablet or a mobile phone or other device 'app'.

It is important that the information we hold about you remains accurate and up to date. Please let us know of any changes in your contact and other personal details.

The information we hold about you will be used for the purposes of providing advice and treatment to you, referrals to other health professionals, obtaining advice from other health professionals on x-rays, other images, tests or treatment options, managing our accounts and billing your health fund or insurer, for our practice clinical quality management, training of our staff and for investigation and resolution of any concerns you may have about our services to you. Due to legislative requirements or a court order (e.g. subpoena), we may be required to disclose information about you to regulators, law enforcement bodies or other parties

without your prior knowledge or consent. Subject to any legal constraints, we will use reasonable steps to let you know of these requests.

We may also use the contact information you provide to keep you updated on our services and other dental or health improvement products or services that we feel are relevant to your dental health or we think may be of interest to you. If you do not want to receive this information, please let us know.

We will take appropriate steps to protect the security of the information we hold about you, including protection against unauthorised access, virus or other electronic intrusions, fire, theft or loss. Your electronic records are protected by a security password. Your paper records are kept in secure filing cabinets and accessible only by practice staff. Our staff are bound by strict requirements regarding protection of the privacy and confidentiality of your dental records as a condition of their employment with us.

We store your records at our practice and in electronic systems under our control. As a patient of this practice you have the rights of access to the information we hold concerning you. Should you wish to access this information, please ask our staff.

As part of our commitment to improving the quality of our dental services, we may participate in research programs, professional development and other educational activities. We may use the information we hold about you to assist with this research and education. However, this information will not identify you unless we have received your agreement to do so or the research study has been approved by a research ethics committee that complies with the National Health and Medical Research Council guidelines and applicable privacy law.

We will keep your dental records after you cease to be a patient of the practice. This is to enable us to provide information to your future dentist if required and for medicolegal reasons. Legislation also requires us to keep your records for a number of years after you cease to be a patient of the practice.

Should you, at any time, have a query or concern in relation to our privacy policy and/or management of your information please let our staff know and they will be happy to address any concerns you may have. If your concerns are not resolved by our staff, or you have a complaint about our privacy management, please advise Dr Meredith Gay. We will make our best endeavour to address your complaint within 30 days of receipt of your complaint. If you are not satisfied by our response, you have a right to make a complaint to the Commonwealth or State/Territory Privacy Commissioner and we can provide you with their contact details.