Suite 30 Gordon Village Arcade 767 Pacific Hwy Gordon NSW 2072
T:94181099

NORTH SHORE DENTAL PRACTICE

Patient Medical & Dental History

Title: Dr / Mr / Mrs / Ms Surname: ..... Given Name: .....

Address: ..... Suburb: .....

Postcode: ..... Date Of Birth: .....

Phone:(Home/work) .....

Email.....

Mobile: ..... Private Health Insurance .....

Occupation: .....

Who, if anyone, recommended us to you: .....

How would you like to receive recalls (tick one):

☐ Email ☐ SMS ☐ Phone call

Do you identify as being of Aboriginal and/ or Torres Strait Islander origin? Yes/No

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Please circle the appropriate answer:

1. Are you currently under treatment from your doctor? Yes/No
2. Are you taking ANY medication prescribed by your doctor? If yes, please list Yes/No

   .....
3. Have you been hospitalised in the last 2 years? If yes, please describe briefly Yes/No

   .....
4. Do you have any Allergies (e.g. Penicillin or Latex)? If yes, please describe briefly Yes/No

   .....
5. Have you ever had any of the following? If so, please tick as appropriate:

☐ Rheumatic Fever	☐ Arthritis	☐ Diabetes
☐ Heart Problem	☐ Hepatitis B or C	☐ Kidney Problem
☐ High Blood Pressure	☐ Bleeding Disorder	☐ Epilepsy
☐ Asthma	☐ Severe Headaches	☐ Bone Disease / Osteoporosis

6. Have you ever had any Prosthetic Surgery (e.g. Heart valve or hip replacement)? Yes/No

   Details:

   .....

   .....
7. Have you ever had Radiotherapy or Chemotherapy? Yes/No
8. Are you HIV positive or do you consider yourself at risk to HIV exposure? Yes/No
9. Women: are you or could you be pregnant? Yes/No

10. Are you a Smoker? Yes/No
11. Have you had any history of:
    a) reaction to drugs or materials used in a dental surgery? Yes/No
    b) difficult extraction(s)? Yes/No
12. Any other Medical Problems we should be aware of? If yes, please detail Yes/No

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13. Emergency contact person details:

Name: ..... Relationship: ..... Phone: .....

Patient Health Information Consent Form

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act of 1988 and Australian Privacy Principles (March 2014), we wish to provide you with sufficient information on how your personal health information may be use or disclosed and record your consent or restrictions to this consent. Your personal health information will only be used for the purpose for which it was collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: Dental examination findings, notes from consultation, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (eg: specialist correspondence).

By signing below, you as a patient are consenting that on obtaining your personal contact and health information it may be used or disclosed by the practice for the following purposes:

- For appointments/follow- up/reminder/notices/preventive healthcare planning via email, telephone or SMS.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialist and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by other professionally trained and qualified persons
- For legal disclosure as required by a court of law.
- For the purpose of research only where de-identified information is used.
- To allow dental staff to participate in medical training/teaching using only de-identified information.
- For use when seeking treatment by other clinicians in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, ... give my permission for my personal contact and health information to be collected, used and disclosed as described above. I understand only my relevant information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Signature: ..... Date: .....