curtindental
20 Strangways St, Curtin ACT 2605
Dale Lymn BDS (Adel) Niran Pathmaperuma BDSc (Qld)
Helen Cullinan BDS (Syd) Jessica Shirley BDS (Syd) & Associates

PATIENT INFORMATION RECORD

Surname: .... Dr/Mr/Mrs/Ms/Miss (circle)

Given Name(s) : .... Date of Birth: ....

Residential Address: ....

.... Suburb: .... Postcode: ....

Postal Address: ☐ Same as residential address / or;

Postal Address: ....

.... Suburb: .... Postcode: ....

Telephone: (hm) .... mobile: .... (wk) ....

Email: ....

Emergency Contact Name: .... Relationship: ....

Contact Phone: ....

Health Fund: .... Line ID No.: ....

How did you hear about us? (Please circle) Family/Friend Website Yellow Pages Online Promotion

THIS INFORMATION IS STRICTLY CONFIDENTIAL

To assist us in assessing your general state of health, would you please answer the following questions relating to your health. Please use the back page if you require further space.

1. When was you last dental treatment (approximately)? ....
2. Last Dental Clean? ....
3. Last Full Mouth X-rays? ....
4. Are you currently taking any medication, drugs or pills? YES .... NO ....
   If yes, name and dosage ....
5. Are you currently undergoing any medical treatment? YES .... NO ....
6. Do you have any allergies? YES .... NO .... **Please list** ....
7. Are you pregnant or nursing? YES .... NO ....

Please indicate below if you have had, or have at present, any of the following?

- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Haemophilia
- ☐ HIV
- ☐ Blood Thinning Medication
- ☐ Tuberculosis
- ☐ Smoker
- ☐ Asthma / Hay Fever
- ☐ Sinus Concerns
- ☐ Emphysema/ Chronic cough
- ☐ Radiotherapy/ Chemotherapy
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Dizzy spells
- ☐ Bisphosphonate Medication
- ☐ Artificial Joints - Hip/Knee
- ☐ Arthritis / Rheumatism
- ☐ Stomach Ulcers / Reflux
- ☐ Latex Sensitivity
- ☐ Other

Please turn over

Would you like to improve your smile? ❑ YES ❑ NO

If so, would you change? ❑ Colour ❑ Straighter ❑ Shape ❑ Gap

Payment is expected at the time of your visit, how will you be paying today?

❑ Cash ❑ Hicaps* ❑ Eftpos ❑ Credit Card

**Please note, hicaps may only be a part payment dependant on your health fund level of cover*

Privacy and Consent Statement

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.

You may inspect or request copies of your treatment records at any time or seek an explanation from the dentist. If you want copies, a fee may apply. If you require a detailed explanation of your records or 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 details change. If any other information we have about you is inaccurate, you may ask us to alter our records accordingly.

We will be unable to disclose any of your information to anyone other than yourself without your written consent. We will take all reasonable steps to protect this information from misuse, loss and unauthorised access.

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.

☐ *I have read the Privacy and Consent Statement and understand my obligations.*

FINANCIAL OBLIGATIONS (please read and sign your agreement below)

It is a policy of this Practice that **PAYMENT IS MADE AT THE TIME OF TREATMENT.**

Payment can be made by cash, cheque, credit card or EFTPOS. If you are having financial difficulties, please discuss this with the Practice Manager **PRIOR TO YOUR APPOINTMENT.** It is a policy of this Practice **NOT TO MAKE ANY FURTHER APPOINTMENTS UNTIL THE ACCOUNT HAS BEEN FINALISED** unless authorised by the Practice Manager.

(I declare that the information given above is true and correct.}

Sign here .... Date: ....

(Please print your full name & relationship to patient if signing on behalf of child) ....