



20 Strangways St, Curtin ACT 2605
 Niran Pathmaperuma BDS (Sri Lanka) BDS (Qld) FICOI
 Tiffany Tam BDS (Melb) (Hons)
 Nitin Pandey BDS ADC Post Grad Dip

PATIENT INFORMATION RECORD

Surname: Dr/Mr/Mrs/Ms/Miss/Master (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:

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

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?

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

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 a child)