Patient History

Please take your time to provide the following information as accurately as possible. Your co-operation assists us in providing the professional service to which you are entitled. Details of your health assist us in treatment planning.

My personal details

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

Preferred Name: ..... Date of Birth: ..... Today's Date: .....

Home Address: ..... Suburb: ..... Postcode: .....

Postal (if different) : ..... Your Doctor: ..... Your Dentist: .....

Email: ..... Occupation: .....

Phone: Home: ..... Mobile: ..... Work: .....

Private Health Insurance with: ..... Membership No: ..... D.V.A. No: .....

Pension/Healthcare Card No .....

My medical history Please indicate if you have or ever have had any of the following:

	YES	NO		YES	NO
High blood pressure	○	○	Diabetes	○	○
Heart problems, defects or pacemaker	○	○	Thyroid problems	○	○
Rheumatic fever	○	○	Excessive bleeding or blood disorder	○	○
Asthma, chest or breathing problems	○	○	Epilepsy	○	○
Tuberculosis	○	○	Hepatitis	○	○
Stomach or bowel problems or ulcers	○	○	AIDS / HIV	○	○
Kidney disease	○	○	Cancer	○	○
Anxiety or depression	○	○	Any other contagious disease	○	○
Do you have any heart valve, hip or other prosthetic implant?				○	○
Do you have any allergies?				○	○
Please list any medications you are presently taking;				○	○
Is there any other medical condition that you wish to discuss in private?				○	○

How will you be paying your fee? (tick) Cash ○ Cheque ○ Eftpos ○ Health Fund ○ Credit Card ○

Denture history

What service do you require today? .....

How old are your current dentures? ..... Does your jaw ever click or pop? .....

Do you suffer headaches or facial pain? ..... Are you happy with current appearance? .....

Have you had injury to head or neck? ..... What changes are you hoping for? .....

Please complete Privacy Consent on the other side of this form

Privacy Consent Form

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Your Dental Prosthetist (DP) collects information from you for the primary purpose of providing quality dental health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your dental health care needs. This means we will use the information in the following ways:

- Administrative purposes in running this Denture Clinic, including billing.
- Health Fund / Health Insurance Commission requirements.
- Disclosure to others involved in your dental health care, including treating doctors, dentists or other dental specialists outside this denture clinic practice. This may occur through referral to a doctor, dentist or dental specialist.

The records of each consultation will be maintained and referred to by your DP in the management of any dental health problem that may arise.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this Denture Clinic has a privacy policy on handling personal patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the dental health treatment and care given to me and potentially place myself at risk.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than as set out above, my further consent must be obtained.

I consent to the handling of my information by this Denture Clinic for the purpose set out above, subject to any limitations on access or disclosure that I notify this Denture Clinic of.

I consent to being included on the recall database of this Denture Clinic, as detailed above.

Patient Name (print) .....

Patient Signature ..... Date .....

What is your preferred method of correspondence SMS ○ email ○ mail ○

Do you give us permission to send you SMS reminders about appointments YES ○ NO ○

Do you require an interpreter or carer to be present with you at consultations? YES ○ NO ○
If yes please give details. .....

You are welcome to have a copy of this document. Do you want a copy? YES ○ NO ○