MEDICAL & DENTAL QUESTIONNAIRE

Strictly confidential

Title _____ **Pronoun** _____ **D.O.B.** _____ / _____ / _____

First Name _____ **Mobile** _____

Surname _____ **Phone** _____

Address _____ **Suburb** _____ **Post Code** _____

Email _____

Occupation _____

Person responsible for my accounts ❑ Myself ❑ Parent ❑ Other _____

Do you have private dental insurance ❑ No ❑ Yes **with** _____ **Member #** _____

Personal Reference # _____

Are you of Aboriginal or Torres Strait Islander Decent? ❑ No ❑ Yes ❑ Prefer not to say

Is English your first language? ❑ Yes ❑ No - If no, please specify (optional) _____

EMERGENCY CONTACT

Name _____ **Medical Doctor** _____

Relationship _____ **GP Address** _____

Phone / Mobile _____ **GP Phone** _____

MEDICAL HISTORY – *Please tick where applicable including <u>past and current</u> conditions.*

❑ Anaemia / bleeding disorders
❑ Arthritis / rheumatoid arthritis
❑ Artificial joint
❑ Asthma / respiratory problems
❑ Blood pressure high / low
❑ Cancer / tumours
❑ Epilepsy
❑ Diabetes type 1 / type 2
❑ Hayfever
❑ Heart conditions
❑ Hepatitis A / B / C
❑ HIV / AIDS
❑ Kidney disease
❑ Liver disease
❑ Osteoporosis
❑ Pacemaker
❑ Psychological disorders
❑ Radiation therapy
❑ Rheumatic fever
❑ Sinus trouble
❑ Stroke
❑ Surgery / general anaesthetic
❑ Recreational drugs
❑ Smoker/Vape _____ per day
❑ Pregnant Due _____
❑ **Allergies** _____
❑ Disability _____
❑Other _____

Have you ever taken bisphosphonate medications? ❑ Yes ❑ No

Are you currently undergoing any medical treatment? ❑ Yes ❑ No

MEDICATIONS & TABLETS – *Please list all prescribed medications and over the counter supplements/vitamins you take.*

Medication / Tablet	Strength/Frequency

Medication / Tablet	Strength/Frequency

DENTAL HISTORY – *What dental/oral problems are you experiencing/concerned about? Please tick as many as applies to you.*

❑ Bad breath
❑ Broken tooth / filling
❑ Crooked teeth
❑ Grinding / clenching
❑ Loose teeth
❑ Missing teeth
❑ Second opinion
❑ Sensitivity hot / cold

❑ Cavity (hole) ❑ Gums bleeding / infected ❑ Pain / toothache ❑ Tooth discolouration

Please describe your dental/oral problem or concern in detail.

_____

_____

When was your last dental appointment? _____ Treatment_____

❑ *I declare the above information as correct to the best of my knowledge.*

❑ *I understand the importance of informing this clinic of any changes to my health.*

Patient / Parent / Guardian Signature _____ Date _____ / _____ /_____ **P.T.O**

PRACTICE POLICY & HEALTH PRIVACY

Welcome to Northland Dental Clinic

Thank you for choosing the team at NDC to care for you and your family's dental needs.

Oral health is an integral part of overall well-being, and as such it is our vision and legal duty to provide comprehensive professional care and advice suitable to your personal needs.

In accordance with the *Victorian Health Records Act 2001* and the *Privacy Act 1988 (Commonwealth)*, we respect your privacy rights in the handling of your personal details and health information. Any information collected will be treated with strict confidentiality. It is important to us that you understand the purpose for which this is collected, how it is used and/or disclosed to other health care professionals.

At NDC, we follow the below practice policy and health privacy procedures to ensure ethical and quality services to all patients under our care.

- WHAT INFORMATION IS COLLECTED AND WHY. Any information collected is used to assist us in managing your dental care needs and the way in which we provide our health services to you. This includes but is not limited to your personal details as well as physical and psychological health.

- HOW YOUR INFORMATION IS USED. Any health information collected from you is essential for diagnosis, planning treatment and after care. Personal information including contact details will only be used for the purpose of communicating your treatment and our services. Any records of verbal and written information will be securely stored.

- OTHER USES OF INFORMATION. We may share with and/or disclose your personal and health information to other health care professionals (e.g. specialists) where deemed necessary and relevant to your treatment. Investigations and research studies may also benefit from the collected information for evaluation and other quality control purposes. In this instance, your identity will be protected.

- YOUR RIGHTS AND OBLIGATIONS. *According to standards set by law, you are expected to, truthfully, disclose any personal and health information known to you as it may affect test results, treatment options and outcomes, current conditions, recovery, future health risks and your overall health care management plan.* If in doubt, we encourage you to inform your health professional. You may access, inspect and request copies of your records at any time, however, a formal application and statutory fees may apply.

- SETTLEMENT OF ACCOUNTS. We are pleased to offer onsite HICAPS health insurance claims and accept payments via cash, EFTPOST and credit card. We require that you settle all fees payable on the day of your appointment. ❑ **Yes, I am aware**

- APPOINTMENT DEPOSITS. In preparation for future treatment, we may take a deposit to secure your appointment. This deposit will then be used towards your dental treatment at your next visit.

  ❑ **Yes, I am aware**

- **CANCELLATION POLICY**: Should you need to reschedule an appointment, we request **48-hour advance notice** for appointments. **Failure to attend a booked appointment or short notice rescheduling will incur a fee.** ❑ **Yes, I am aware**

- **Would you like to discuss finance options with our friendly reception staff? (optional)** ❑ Yes ❑ No

How did you discover us? ❑ Passing by ❑ Website ❑ Google ❑ Other _____

For "word of mouth" referral sources, whom may we thank? *(name)* _____

Should you have any questions or concerns regarding the practice policy and health privacy, please do not hesitate to discuss these with our friendly team members.

Please complete the section below as a confirmation that you have read, understood and consent to our practice policy and health privacy procedures.

Patient Name _____

Patient / Parent / Guardian Signature _____

Date _____/ _____/ _____