Victorian Dental Scheme Veterans Affairs Health Fund Private

GEELONG SMILES DENTURE CLINIC

PATIENT INFORMATION

Surname **……**

Given Name ……. Date of Birth ……..

Address …… Postcode ……..

Telephone …….. Mobile ……

Email…… Doctor's Name ……

Please circle if you have ever had the following:

Heart Trouble	High Blood Pressure	Stroke	Asthma
Chest Trouble	Fits of Epilepsy	Allergies	Diabetes
Rheumatism	Rheumatic Fever	Arthritis	Hepatitis

Have you visited a medical doctor in the last 3 months? Yes/No

Are you currently taking medication? Yes/No

Do you suffer from a dry mouth? Yes/No

Do you have allergies? Yes (which)……../ No

Do you belong to a health fund that includes dental? Yes (which)……../ No

How did you hear about us?

……

……

Please sign this form to indicate that you have provided the correct information and understand that this record will be kept completely confidential.

We will comply with the Commonwealth Privacy Act 1998 and its National Privacy Principles and the Victorian Health Records Act 2001.

Please read the Privacy Consent Form on the back of this page and sign.

Privacy & Treatment Consent Form

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

This Clinic 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 other involve in your dental health care, including treating doctors, dentist 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 problems 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 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 by 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 give consent to the handling of my information and by the Clinic for the purpose set out above, subject to any limitations on access or disclosure that I notify this Clinic of.

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

I also give consent for the Dental Prosthetist to commence the treatment, which he has explained and I fully understand the procedure.

Signature…… **Dated**……