STRATHPINE DENTAL CENTRE

Welcome to Strathpine Dental Centre

To help us give you the best possible treatment, please answer the following *confidential* questions to help us get to know you better and understand your dental needs.

Title: Dr / Mr / Mrs / Ms / Miss / Master *(please circle)*

Surname: _____

First Name: _____

Preferred Name: _____

Address: _____

_____

Suburb: _____ **Postcode:** _____

Occupation: _____

Date of Birth: _____ /_____ /_____

Contact Number: _____

Email: _____

Are you covered for Dental by a Health Fund?

☐ Yes ☐ No

Health Fund Name: _____

How long since your last dental examination?	☐ < 1 year ☐ 1-2 years ☐ 2-5 years ☐ > 5 years	
Are you currently receiving medical treatment?	☐ Yes, *details*: _____	☐ No
Have you ever suffered a serious illness?	☐ Yes, *details*: _____	☐ No
Do you have **any allergies?** *(foods/medicines/latex/etc)*	☐ Yes, *details*: _____	☐ No
Any past dental treatment we should know about?	☐ Yes, *details*: _____	☐ No
Are you currently taking **any** medications?	☐ Yes, *please list*: _____ _____ _____	☐ No
Are you on any medication/injections for **boneweakness / osteoporosis?** *(if yes please circle)* Fosamax, Actonel, Aclasta, Zometa, Bonvia, Prolia (Denosumab)	☐ Yes ☐ Other: _____	☐ No
Do you snore or have sleep apnoea?	☐ Yes	☐ No
Have you taken aspirin or **Blood Thinners** in the past two days?	☐ Yes	☐ No
Have you taken steroids in the last two years?	☐ Yes	☐ No
Are you pregnant or breastfeeding? *(females only)*	☐ Yes	☐ No
Do you normally require antibiotic cover before dental treatment?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Have you had any abnormal reaction to anaesthetics?	☐ Yes	☐ No

Please tick and circle if you have or have had any of the following conditions:

☐ Heart attack, disease, surgery, murmur, disorder or complaint	☐ Epilepsy	☐ Radiation Therapy
☐ Cardiac pacemaker	☐ Transplants	☐ Cancer
☐ High or low blood pressure	☐ Kidney / liver disease	☐ Asthma
☐ Angina	☐ Tuberculosis	☐ Hepatitis (A / B / C)
☐ Respiratory disease	☐ Stroke	☐ HIV or AIDS
☐ Bruise / bleed excessively	☐ Bone disease	☐ Diabetes (I / II)
☐ Artificial joints	☐ Blood disease	☐ Rheumatic fever
☐ Other: _____	☐ Lung disease	☐ Thyroid disease

How did you hear about us? *(please circle)*

Google search / Yellow Pages / Facebook / Signage / Newsletter / Health fund / Smiles.com.au / HealthEngine / QLD Health / WhatClinic / Friend or word of mouth / Other Promotion: _____

Please Note:

- ✓ Payment is required at the end of all visits, as we do not operate accounts.
- ✓ I have read and consent to the Privacy Policy on the handling of patient information as supplied overleaf.
- ✓ If you must cancel your appointment, we require 24 hours' notice, or a cancellation fee may apply.
- ✓ You are giving consent to be examined and / or treated by our dental staff.

Patient Signature: _____ **Date:** _____ /_____ /_____

Parent/Guardian Name: _____ *Parent/Guardian Signature:* _____

(Parent/Guardian please write your full name and sign above, if the patient is a child under 18 years of age)

Updated Patient Signature: _____ Date: _____ /_____ /_____

(Updated Patient Signature is for returning patients to sign, indicating their details have not changed since their last appointment)

Thank You!

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CONSENT FORM

FOR USE OF PERSONAL INFORMATION

In accordance with the Commonwealth Privacy Act 1988, the introduction of the Australian Privacy Principles (AAP) and complying with the Dental Board of Australia's Code of Conduct a patient can expect that their personal health and other information will be collected, used, disclosed and stored in accordance with the relevant laws around Privacy. These regulations define how Strathpine Dental Centre manages your private information.

What information will we request from you and why?
Strathpine Dental Centre will collect information from you primarily to ensure we are able to provide a proper diagnosis along with the highest quality dental treatment and ongoing care. We require your personal details along with a full medical history to enable our practitioners to access accurate information about you and care for you in the best possible way. This will include your name, address, phone contact and health fund details along with the completed Medical History Form.

We are required to obtain your consent to collect personal data about you and will use the information collected for the following purposes:

- Communication with yourself
- Accounts and billing purposes
- Disclosure to third parties involved in your healthcare such as, other doctors / referral for medical tests
- Use for research / study purposes in improving community healthcare practices (with anonymity)
- Emergency situations whereby medical officers / hospitals require access to patient information

How do we collect this data and how is it stored?
We will collect this information directly from you in a respectful and confidential manner in private facilities if required. All staff and practitioners adhere to the Practice's Privacy Policy and are bound by confidentiality clauses. Patient data is stored electronically in the Practice on secured protected computer systems.

Can I access my personal information?
Strathpine Dental Centre welcomes patient requests to inspect or request copies of their treatment records. If you have changes to your personal information or wish to review this information, please speak with the Clinical Coordinator or your practitioner.

Privacy Policy
This consent form is based on Strathpine Dental Centre's Privacy Policy. If you wish to read this document in full prior to signing please ask our staff for a hard copy.

PATIENT PRIVACY CONSENT

- ✓ I understand the information supplied above and the reasons for collection of my information
- ✓ I am not obliged to disclose this information but understand failure to do so could compromise the quality of healthcare and treatment undertaken by Strathpine Dental Centre
- ✓ I am aware I can access the full Privacy Policy

By signing overleaf, I am consenting to the above.