Patient Medical History and Information Consent form

Gateway Dental Health Pty Ltd, Shop 3, 66A Slobodian Avenue, Eight Mile Plains, QLD 4113

As a patient of our dental practice 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 meeting your oral health care needs. Please read this consent form carefully, and sign where indicated below.

We aim to protect the privacy and secure storage of your health information in accordance with privacy legislations and the guidelines issued by the Australian Dental Association. Your personal information will be treated as confidential and will not be shared with third parties unless necessary as part of your treatment. We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in the provision of your dental care.
- Billing purposes, including compliance with Medicare and Health insurance requirements.
- Disclosure to others involved in your healthcare including treating dentists, doctors and specialists outside this dental practice. This may occur through referral, for medical tests, and in the reports or results returned to us.
- Disclosure to other dentists in the practice, locums etc. attached to the practice for the purpose of patient care, teaching and treatment planning.
- To comply with any legislative or regulatory requirements eg. Notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

I have read the information above and understand the reasons why my information must be collected.

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

I am aware of my rights to access the information collected about me or request a copy.

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

○ I consent to the handling of my information by Gateway Dental Health Pty Ltd for the purposes set out above, subject to any limitations on access or disclosure of which I notify the practice.

OR

○ I am unsure and would like to discuss this further with someone from the practice before I sign.

Patient's name ____________________________ Date _____________________

Patient's signature ____________________________

Parent or Guardian (if you are under 18 years old) ___________________

Name printed _____________________________

*Please note that our policy is to receive payment on the day of your treatment. Thank you.

Thank you for choosing Gateway Dental Health. We are here to provide you with the very best dental care possible in a safe and relaxing environment. Please help us achieve this by completing the following medical and dental history form as accurately as possible.

First name: _ Last name: _

Preferred name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Title (please circle): Mr / Mrs / Ms / Miss / Dr

Postal Address: _

Suburb: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Postcode: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Ph no (Home): _ _ _ _ _ _ _ _ _ _ Ph no (Work):_ _ _ _ _ _ _ _ _ _ _ Mobile: _

Email: _ Preferred method of contact: Call / SMS / Email

Date of Birth: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Occupation: _

Are you interested in whitening your teeth? Y / N Would you like to join our email list? Y / N

How did you hear about us? ○ Word of mouth ○ Google search ○ Facebook ○ Signage

(Tick all that apply) ○ Google reviews ○ Google ads ○ Live locally ○ Flyer

How would you rate your smile? (10 being the best) 1 2 3 4 5 6 7 8 9 10

Emergency Contact

Name of alternate contact person: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Relationship: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Alternate contact phone number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Billing Information

Do you belong to a health fund? ○ Yes ○ No

Which fund? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Membership number: _ Reference number (your # on card): _ _ _ _ _

Who would you like bills made out to? ○ Myself ○ Other: _

Address (if someone else): _ Phone: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I have confidential medical information that I do not wish to write down, I would prefer to speak to the dentist privately about this. Please tick if this applies to you: ○

GATEWAYDENTAL HEALTH

Confidential Medical History

Have you been under the care of a medical doctor / specialist in the past few years? ○ Yes ○ No

If yes, what for? _

Do you normally require antibiotics before dental treatment? ○ Yes ○ No Do you smoke? Yes / No

For Ladies, are you: Pregnant: ○ Yes ○ No If yes, how many months? _ _ _ _ _ _

Possibly pregnant: Yes / No Nursing: Yes / No Taking birth control pills: Yes / No

Antibiotics may influence the effectiveness of oral contraception, please advise your dentist if this is relevant to you.

Please list <u>any</u> medications you are taking (including cold/flu):

_ _

Have you or anyone else in your household returned from overseas travel in the last 10 days? Yes / No

Have you ever had Hepatitis or been advised that you may be a carrier? Yes / No

Is there any reason for you to suspect that you are in a risk category for infectious diseases (eg. HIV, AIDS) or any other immuno-compromising condition? Yes / No

Please list <u>any</u> known allergies (eg. latex, foods and preservatives):

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Do you have, or have you ever had any of the following conditions (Tick any that apply):

- Heart disease / disorder
- Heart valve problems
- Cardiac / Heart Transplant
- Chemotherapy / Radiotherapy
- Prosthetic implants (eg. artificial joints)
- Rheumatic Fever
- Diabetes (Insulin/Diet)
- Reaction to anaesthetic
- Epilepsy or seizures
- Cardiac Pacemaker
- Bone Disease (including osteoporosis)
- Excessive bleeding
- Bruise Easily
- Stroke
- Asthma
- Tuberculosis
- Thyroid problems
- Sinus Troubles
- High / low blood pressure (Circle which one applies)
- Steroid treatment
- Anaemia, Leukaemia or other blood diseases
- Tumors
- Diet (special/restricted)
- Bronchitis, Emphysema or other lung diseases
- Anaemia / Cold Sores
- Heartburn / Reflux
- Nervous / Anxious
- Fainting / Dizzy spells
- Stomach Ulcers
- Latex Sensitivity
- Neurological disorders

Please list any disease or condition not listed above:

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Your/Guardian Signature: ______________________________ Date: ____________________________

Dentist Signature: ____________________________________ Date: _____________________________