

Title Dr / Mr / Mrs / Miss / Ms/ Other _____

Surname _____ First name _____ Date of birth ___/___/_____

Preferred name _____

Home address _____

_____ Postcode _____

Postal address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

Email _____

Health fund for dental cover _____ Membership No. _____ Patient ID. _____

Medicare Card No. _____ Veterans' Affairs Card No. _____

Occupation _____

Emergency contact _____ Relationship to patient _____ Contact No. _____

Person responsible for account (must be completed if patient under 16, if same as above please tick here)

Name _____ Relationship to patient _____

Address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

If third party, insurance company/employer responsible for account _____

Medical Questionnaire – Private and Confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/Current medical conditions:

Are you receiving any medical treatment at present Y N Details _____

Have you had any serious or long standing illness Y N Details _____

Have you ever been hospitalised Y N Details _____

Please indicate if you have EVER had any of the following:

- | | | | |
|--|---|--------------------------------------|---|
| Any heart complaint/treatment | Y <input type="checkbox"/> N <input type="checkbox"/> | Tuberculosis | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Rheumatic fever or heart valve surgery | Y <input type="checkbox"/> N <input type="checkbox"/> | Any nervous system disorder | Y <input type="checkbox"/> N <input type="checkbox"/> |
| High or low blood pressure | Y <input type="checkbox"/> N <input type="checkbox"/> | Gastric ulcer | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Blood Disorders | Y <input type="checkbox"/> N <input type="checkbox"/> | Asthma/Bronchitis /lung conditions | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Anti-coagulant therapy | Y <input type="checkbox"/> N <input type="checkbox"/> | Radiation therapy/chemotherapy | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Joint replacement surgery | Y <input type="checkbox"/> N <input type="checkbox"/> | Thyroid disease | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Osteoporosis or low bone density | Y <input type="checkbox"/> N <input type="checkbox"/> | Hepatitis, jaundice or liver disease | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Epilepsy | Y <input type="checkbox"/> N <input type="checkbox"/> | Treatment for any form of Cancer | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Diabetes | Y <input type="checkbox"/> N <input type="checkbox"/> | Transplanted organ or bone marrow | Y <input type="checkbox"/> N <input type="checkbox"/> |
| HIV | Y <input type="checkbox"/> N <input type="checkbox"/> | Pregnant (when due) _____ | Y <input type="checkbox"/> N <input type="checkbox"/> |

Other _____

Do you smoke Y N Social

Current medications (prescription, over the counter, herbal) _____

Allergies Nil known Yes - Details _____

Medical practitioner _____ Suburb _____

I agree that the above is a true and accurate record. I understand that this Pacific Smiles Dental Care Centre requires payment on the day of treatment. Any expenses, costs or disbursements incurred by the Pacific Smiles Dental Care Centre in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled. I have read and agree with the privacy statement on the back of this document.

PLEASE NOTE: The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

X Signature _____ Date ___/___/_____

OFFICE USE ONLY.

Form checked by _____ Data keyed by _____ Keying checked by _____ Form scanned by _____

PRIVACY STATEMENT

Pacific Smiles Group Limited (“PSG”) respects your right to privacy and considers all of the information you have provided in this form to be personal information for the purposes of the Privacy Act 1988 (C’th) as amended (“Privacy Act”).

Why PSG collects your personal information?

PSG collects your personal information primarily to enable it to provide health care services to you in the most appropriate and efficient way. PSG, its related companies or agents (“Related Persons”) may also use this information to promote health and related services to you or for other purposes permitted under the Privacy Act.

How PSG collects your personal information

Where possible we collect your personal information directly from you and where that is not reasonably practicable we may collect your personal information from other sources.

PSG may collect personal information directly from you when:

- you complete a medical history form such as this one;
- you request information concerning PSG’s services in person, by phone or online.

In addition we may collect personal information from Related Persons or health service providers such as health insurers, government agencies, hospitals, doctors and medical specialists.

We may provide information to Related Persons of PSG to assist them in developing and promoting health-related products and services that may be of interest to you (unless you ask us not to).

How does PSG use your personal information?

PSG uses your personal information in accordance with National Privacy Principles. The personal information is used to:

- provide you with health and related services, including appointments and follow up services;
- promote the health-related products and services of PSG and Related Persons.

Your agreement

By providing your personal information to us in this form or by other means you acknowledge and agree that PSG may:

- collect and use your personal information to provide health and related services to you;
- collect and use your personal information to contact you for market research and to provide you with information and offers about health-related products and services offered by PSG and Related Persons; and
- disclose your personal information on a confidential basis to Related Persons who may contact you for promotional and informational purposes in relation to health-related products and services.

Our staff may contact you on available telephone numbers and email addresses. When our staff contact you and you are not available, they may leave messages which identify the caller or sender and the purpose for which the communication is made.

Whenever you are provided with market research or marketing information by PSG or Related Persons you will be offered the opportunity to inform us if you do not want your personal information to be used for those purposes in the future.

Please refer to PSG’s Privacy Policy at www.pacificsmilesdental.com.au for further details or contact the Privacy Officer via email to privacy.officer@pacificsmiles.com.au or mail to The Privacy Officer, PO Box 2246, Greenhills, NSW 2323, should you have any questions, comments or concerns regarding privacy matters or you do not want your personal information used for marketing purposes.