
Shop 3, 46 Tennyson Road
Mortlake, NSW 2137
Tel: (02) 9739 6525
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# Patient Information & Consent Form

*To maintain your medical records. it is important to have the following information, which will be handled confidentially. We have attached a copy of our privacy policy for your perusal.*

Title: ____ Surname: _____ Given Name(s): _____

Preferred Name: _____ Date of Birth: _____

Occupation: _____

Address: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ E-mail: _____

Emergency Contact Name and Number: _____

Previous Dentist: _____ GP: _____

## Some General Questions Regarding Your Health

Please complete the following questionnaire to assist us in ensuring we provide you with the best care. All information is treated with the strictest of confidence.

| | | | |
|---|---|---|---|
| Hepatitis or liver trouble: | Yes / No | High blood pressure: | Yes / No |
| Asthma: | Yes / No | Kidney trouble: | Yes / No |
| Arthritis: | Yes / No | Rheumatic fever: | Yes / No |
| Osteoporosis: | Yes / No | Skin problems: | Yes / No |
| Bronchitis or lung disease: | Yes / No | Smoking: | Yes / No |
| Chest pain: | Yes / No | Stomach or bowel problems: | Yes / No |
| Diabetes: | Yes / No | Stroke: | Yes / No |
| Epilepsy or fits: | Yes / No | Thyroid trouble: | Yes / No |
| Excessive bleeding: | Yes / No | Cold sore | Yes / No |
| Heart trouble: | Yes / No | | |

# Health Questions Continued...

Do you have any other medical issues or problems? Yes / No

If yes please give details: _____

_____

**Do you have any allergies? Yes / No please specify: _____**

If you have been recently hospitalised for any reason, please specify: _____

_____

If you are currently undergoing treatment of any kind, please specify: _____

_____

Please specify if you are taking any medication(s): _____

_____

Are you pregnant or could you possibly be pregnant? Yes / No / N/A

Are you breast feeding? Yes / No / N/A

If there is any other relevant information you wish to discuss with the doctor, please specify:

_____

Signature: _____ Date: _____

Please tell us how you heard about us:

- ☐ Yellow pages online
- ☐ Google
- ☐ Flyer
- ☐ Local newspaper
- ☐ Word of mouth / Who Should we thank for referring you to us? _____
- ☐ Walk By/Signage
- ☐ Other: _____

# PAYMENT OF ACCOUNTS INFORMATION

## Payment of your account is due and payable on the day of your treatment

agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Signature: _____ Date: _____

*Payment can be made with Visa, MasterCard, American Express, EFTPOS, Cash, Cheque*

Failing to attend an appointment without notification will result in an invoice which will reflect the amount of time that has been set aside for you. 48 hours notice is required to avoid incurring this fee. We will endeavor to provide a courtesy reconfirmation call/text 48 hours prior to your scheduled appointment via:

SMS: _____ Email: _____ Phone:_____

(Please select the contact method that would suit you best)

# AMK Dental Clinic
## Your Health Information and Our Privacy Policy
### In Accordance with the Privacy Act 2000

Our practice respects your rights to privacy.

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you as well as processing payments and writing to you about issues affecting your treatment.
2. We may disclose your health information to other health care professionals, or require it from them if, in our judgement, it is necessary in the context of your treatment. In this event, disclosure of you personal details will be minimised wherever possible.
3. We may have to copy parts of your treatment records, including x-rays, should other health care professionals, who may be involved in your treatment, request this.
4. We may also use your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should this happen, your personal identity will not be disclosed without your consent to do so.
5. Your patient history, treatment records, x-rays and any other material relevant to your treatment will be kept at our practice. You may inspect or request copies of your treatment records at any time or seek an explanation from the dentist. A fee may apply if you request copies of your records, an explanation of your records or a written summary.
6. If any of the information we have about you is inaccurate, you may ask us to amend our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries about our handling of your health information please do not hesitate to raise those concerns with our practice.

Please sign and date this form as confirmation you have read and understand our privacy policy and consent to use your health information in this way.

Full Name: _____

Signature: _____ Date:_____