HUON VALLEY DENTAL CARE

PATIENT DENTAL & MEDICAL QUESTIONNAIRE

All information on this form is, and will remain, strictly confidential

PATIENT DETAILS

SURNAME ____

GIVEN NAME _________________________Dr /Mr /Mrs /Ms /Miss

PREFERRED NAME : _________________________

DATE OF BIRTH ________/_______/________

POSTAL ADDRESS: ____

_________________________________POSTCODE______________

PHONE (HOME) ___________________________________

PHONE (BUS) ___________________________________

MOBILE ___________________________________

PREFERRED CONTACT NUMBER (please circle)

HOME MOBILE BUSINESS

EMAIL ____

OCCUPATION ___________________________________

EMPLOYER ___________________________________

EMERGENCY CONTACT

NAME _______________________

PHONE ______________________

RELATIONSHIP TO PATIENT:

____

HEALTH FUND INFORMATION

FUND NAME __________________________

PATIENT LINE NUMBER (   )

MEDICARE (applies to Children's Dental (CDBS) only)

CARD NO. __ __ __ __ __ __ __ __ __

PATIENT LINE NUMBER (   )

EXPIRY ___ / ____

DVA NUMBER (Gold Card Only)

MEDICAL HISTORY

Have you ever had, or currently suffer from any of the following?

(please only tick those which apply – LEAVE BLANK IF NOT APPLICABLE)

☐ Kidney disease (please provide details) ________________________________

☐ Diabetes (please advise type) ________________________________

☐ Heart condition (please provide details) ________________________________

☐ Bruising / bleeding

☐ Migraines

☐ HIV

☐ Drug Dependence

☐ Osteoarthritis

☐ Rheumatoid Arthritis

☐ Epilepsy

☐ High Blood Pressure

☐ Low Blood pressure

☐ Depressive Illness

☐ Psychiatric Treatment

☐ Asthma

☐ Gastric problems

☐ Liver disease

☐ Pacemaker

☐ Osteoporosis

☐ Stroke

☐ Joint replacement surgery *(DETAILS)* ________________________________

☐ Artificial Heart Valve

☐ Hepatitis A / B / C (circle relevant)

ANY ADDITIONAL RELEVANT HEALTH PROBLEMS NOT LISTED:

PARENT/GUARDIAN CONTACT DETAILS (IF UNDER 18)

NAME ____ PHONE ____

DO YOU SMOKE? YES / NO **APPROXIMATELY HOW MANY PER WEEK ?** ______

DO YOU HAVE ANY ALLERGIES TO ANTIBIOTICS, MEDICATIONS OR OTHER SUBSTANCES? e.g. Latex, Penicillin (Please list) **YES / NO**

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (please list) **YES / NO**

(NOTE THIS SHOULD INCLUDE ANY HOMEOPATHIC MEDICATIONS)

HAVE YOU EVER UNDERGONE HEART OR JOINT REPLACEMENT SURGERY? **YES / NO**

Please provide any details (including Surgeon/Specialist, month & year) below

ARE YOU UNDER THE CARE OF A SPECIALIST? (Not GP) **YES / NO**

(please provide name/s)

ARE YOU TAKING: (please tick)

- ☐ FOSAMAX
- ☐ OSTEOPOROSIS MEDICATIONS
- ☐ BLOOD THINNING MEDICATIONS

(DO NOT INCLUDE ASPIRIN)

FEMALE PATIENT ONLY:

Are you currently, or do you think you might be pregnant?

YES / NO **DUE DATE ___/____/__**

HAVE YOU BEEN ADVISED THAT YOU REQUIRE ANTIBIOTIC PROPHYLAXIS BEFORE DENTAL TREATMENT (please provide details) **YES / NO**

Consent for contacting General Medical Practitioner (GP)

Name of the Practice: ____________________________________GP name: ___________________________

Practice Address: ____

Consent for the purposes of maintaining and collecting accurate information about your health and in accordance with our Privacy Policy, it is necessary at times for us to contact your GP directly, in order to carry out your treatment safely and effectively.

I *(full name)* ____DOB _______/_____/________

give my Dental Practitioner at Huon Valley Dental, permission to contact my GP or Specialist (if required), in the course of my dental treatment, to obtain or discuss issues that are relevant to my health and/or dental treatment. I understand that this will be in accordance with the Privacy Act 2008 and will be confidential.

Patient/Parent/Guardian signature: _____________________________________ Date: _____/_____/______

HUON VALLEY
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REFERRAL INFORMATION
How did you find us?

☐ **INTERNET/WEBSITE** ☐ **RECOMMENDED BY A FAMILY MEMBER**

☐ **WALK IN/ DRIVE BY** ☐ **RECOMMENDED BY A FRIEND**

☐ **YELLOW PAGES** ☐ **OTHER** ______________________________

DENTAL HISTORY (Only complete this at your first appointment)

If you are **concerned** or **experiencing** any of the following, please **TICK** those that apply.

☐ Sensitivity to hot or cold	☐ Rough existing fillings	☐ Lost fillings
☐ Bleeding gums	☐ worn/broken teeth	☐ grinding or clenching
☐ tooth ache	☐ loose teeth	☐ food trapping
☐ dry mouth	☐ loose / ill-fitting dentures	☐ clicking / jaw pain
☐ ulcers/blisters/lumps	☐ headache / neck ache	☐ bad breath

DO YOU HAVE ANY OTHER DENTAL CONCERNS:

HOW LONG AGO WAS YOUR LAST VISIT TO THE DENTIST?

☐ 6 Months ☐ 1 Year ☐ 1-2 Years ☐ 2-5 Years

☐ 5 Years + ☐ Can't Remember

DOES DENTAL TREATMENT MAKE YOU FEEL NERVOUS?

☐ Never ☐ Slightly ☐ Moderately ☐ Extremely

HOW DO YOU RATE YOUR ORAL HEALTH?

☐ Poor ☐ Fairly Good ☐ Good ☐ Very Good ☐ Excellent

**The information supplied provides the Dentist with important information for your Dental and Oral Health Care. All information is treated with complete privacy and confidentiality.*

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PATIENT AGREEMENT

We would like to take this opportunity to welcome you to the Huon Valley Dental Care Centre. The following is an agreement between Huon Valley Dental Care Centre and the Patient or individual taking responsibility for payment, if someone other than the patient.

In this agreement the words “you,” “your,” and “yours” mean the Patient or individual taking responsibility for payment, if someone other than the patient. The word “account” means the account that has been established in your name to which charges are made and payments are credited. By signing this agreement, you are agreeing to pay for all services that are received.

Required Payments: Unless alternative arrangements are made with the Practice Manager, any co-payments required by Medicare or an insurance company must be paid at the time of service.

Payments: Unless other arrangements are approved by the Practice Manager, the balance on your statement is due and payable at the time treatment is rendered. For procedures requiring multiple appointments with lab fees, our payment expectation is that fifty percent (50%) of the total fee will be paid at the initial visit, and the balance of fifty percent (50%) be paid at the time the service is completed.

Insurance: Insurance coverage is controlled by the contract between you and your insurance company. Huon Valley Dental Care Centre is NOT a party to this insurance agreement, in most cases. Huon Valley Dental Care Centre will bill your primary insurance company via HICAPS as a courtesy to you. It is the insurance company that makes the final determination of your eligibility and insurance benefits. You agree to pay any portion of the charges not covered by insurance.

DVA / Medicare Claims – please refer to the relevant Claim details / patient information.

Overdue Accounts: If your account becomes overdue, we will take necessary steps to collect this debt. If we do have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred.

Missed Appointments: We have a **twenty-four (24) hour** notice appointment cancellation policy. Patients who miss two (2) appointments, either with failure to call and cancel will be asked to transfer their records to another Practice. New patients who fail to attend a confirmed appointment may not be offered any further appointments.

Transferring of Records: Due to Privacy law requirements, you will need to make your request in writing if you want to have copies of your records sent to another doctor or organisation.

Effective Date: Your signature on this agreement indicates you agree to all of the terms and conditions contained in the agreement. The agreement is effective as of the date signed and dated below.

Signed: ____ (Patient/ Guardian / Parent)

Name: ____

Date: ___________/____________/_____________

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YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY

NOTICE FOR PATIENT INFORMATION

Your Health Information and Our Privacy Policy

Our practice respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles. This statement is a brief summary of the practice's privacy policy. The complete policy is available on request.

Our practice ***Huon Valley Dental Care Centre Pty Ltd*** **ABN 814 3445 3425** trading as ***Huon Valley Dental Care*** collects information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your health care. We may collect information about you from third parties providing the collection of that information is necessary to provide you with health care.

We may disclose your health information to other health care professionals, or require it from them if, in our judgment, it is necessary in the context of your care. We may also use parts of your health information for research purposes, in study groups or at seminars; however, in such situations, your personal identity will not be disclosed without your consent.

If you choose not to provide us with information relevant to your care, we may not be able to provide a service to you, or the service we are asked to provide may not be appropriate for your needs. Importantly, if you do not provide information that may be relevant to your care or that is otherwise requested by us, you could suffer some harm or other adverse outcome.

Your medical history, treatment records, x-rays and any other material relevant to your care will be stored by the practice. The practice privacy policy sets out how you can access your records or seek correction of your records.

The practice privacy policy sets out how you may complain about a breach of privacy and how the practice will deal with such a complaint. Please advise if you wish to see a copy of the practice privacy policy.

As part of its electronic records system, the practice may rely on cloud storage providers located outside Australia. The practice will take reasonable steps to ensure that any offshore transfer complies with its obligations under Australian privacy laws.

The practice Privacy Officer (Practice Manager) can be contacted at the practice (or leave a message on 03 6264 1922) during business hours or by email hvdentalcare@gmail.com if you have any concerns or questions about a privacy matter.

Please sign below to confirm that you have read and understand our Privacy Policy, and in signing give your consent to the storage and use of your health information as per the Policy.

Signed: ________________________________ (Patient/ Guardian / Parent)

Name: ________________________________

Date: __________/____________/___________

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THIS SECTION IS USED TO CONFIRM AND UPDATE RECORDS AT FUTURE APPOINTMENTS

DATE	DETAILS	STAFF (Initials)	PATIENT (Initials)

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This list shows possible first appointment (new patient) items which may be billed – note that this may vary on the day.

** These items do not include rebates from private health providers (where applicable)*

ITEM NO.	DETAILS	COST*
011	NEW PATIENT FULL EXAM	$85.00
013	EMERGENCY (LIMITED) EXAM	$85.00
072	INTRA ORAL PHOTOS	$37.00 per set
022	BITEWING (PERIAPICAL) X-RAY	$43.00 each
037	OPG (FULL MOUTH) X-RAY	$104.00
114	FULL MOUTH SCALE & CLEAN	$120.00
019	LETTER OF REFERRAL (if required)	$30.00
071	IMPRESSIONS (e.g. denture planning)	$60.00 each