Patient Registration Form

For our records, and to assist us in providing the best treatment for you, please take the time to answer the following questions as accurately as possible. Please read and fill out **BOTH SIDES.**

Title Miss

Date of Birth / /

Given Names

Surname

Address

Suburb

Post Code

Mobile

Alternative

Email:

Occupation

Who Referred You To The Endodontic Centre:

Contact Details

Emergency Contact Person

Phone

Relationship

Guardian / Carer Name

Please TICK the relevant response

Do you have, or have you ever had:	Yes	No		Yes	No
Asthma	☐	☐	Kidney Condition	☐	☐
Epilepsy / Fits / Blackouts	☐	☐	Bisphosphonate treatment	☐	☐
Heart Condition	☐	☐	High Blood Pressure	☐	☐
HIV / AIDS	☐	☐	Diabetes	☐	☐
Bleeding disorder	☐	☐	High risk of Mad Cow Disease	☐	☐
Liver Conditions (e.g. Hepatitis / Jaundice)	☐	☐	Prosthetic heart valve, hip or joints	☐	☐

Other condition not listed above

Please give details for the following:

Are you **allergic** to anything?

Please list all **medications** you are taking

Take Regular Antibiotic Cover?

History of Rheumatic Fever

If applicable, are you **pregnant?** (Due Date)

Any Unpleasant Dental Experience?

Endodontist Date:

Privacy Policy

(In accordance with the Victorian Health Records Act 2001 and Privacy Act)

The Endodontic Centre respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed. The policy of our practice is to follow these procedures:

- The information collected will be used for the purpose of providing treatment to you. Personal information such as your name and address will be 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 treatment.

- We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

- We may also use parts of your health information for research and teaching purposes. Some material may be presented in lectures or at seminars as this may provide benefits to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

- Your medical history, treatment records, X-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records for your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

- If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise be rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any other person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice. Otherwise, please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

I accept responsibility for my account and understand that the fee is payable on the day. I declare that the information provided in this document is true and accurate.
(Derived from the ADAVB Inc 2002).

Signature _____ Date: / /

Print Name (Patient/Parent/Guardian) _____