PADSTOW IDEAL DENTAL

PATIENT REGISTRATION INCLUDING MEDICAL AND DENTAL HISTORY

Date:________________

Surname: ____

First Name: ______________________________ Title: ___________

Date of Birth: ____________________ Male/Female______________________

Home Address: ____

Home Phone: __________________ Mobile Phone.______________________

Work Phone. : ______________________________ E-mail Address.__________________________

Occupation: ____

Parent's names (**if under 18yrs**): ____

Health Fund: ____

Person to Contact in case of Emergency: ____

Address: ____ Phone.__________________

Person Responsible for Account: ______________________________________

Address: ____

Phone: ______________________________Relationship to Patient: ______________________________

Are you satisfied with the appearance of your teeth? Yes No

Would you be prepared to take necessary steps to keep your teeth? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? ____

Have you ever had an upsetting dental treatment? Yes No

If yes, Describe: ____

Who referred you to this surgery? ____

Medical History

Dr's Name: ______________________ Phone: ______________________

Are you taking any Medication? __________ If yes what? ______________________________________

____

Are you allergic to any Drugs or Medications? ______________________________________

If yes what? ____

Have you been a patient in hospital in the last 5 years? ______________________________________

Have you ever been affected by any of the following? Please circle your answer.

Diabetes	Yes	No	Asthma	Yes	No
Heart Murmur	Yes	No	High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No	Latex Sensitivity	Yes	No
Rheumatic Fever	Yes	No	Hepatitis	Yes	No
A.I.D.S	Yes	No	H.I.V Positive	Yes	No
Kidney Trouble	Yes	No	Liver Disease	Yes	No
Radiation Therapy	Yes	No	Chemotherapy	Yes	No
Tumors	Yes	No	Tuberculosis	Yes	No
Blood Transfusion	Yes	No	Haemophilia	Yes	No

Any Artificial Joint or Valve Yes No If yes what? ______________________________

Heart Related Issues (pacemaker/surgery) Yes No If yes what? ______________________________

Have you ever taken "Bisphosphonate" medication as listed below? Yes No Please circle which

Fosamax Bonefos, Didronel, Didrocal, Aredia, Skelid, Actonel, Zometa

Do you have or have had any disease, condition, or problem not listed? Yes No

If yes please list____

Women: Are you pregnant? Yes No Months__________ Nursing Yes No

PLEASE TURN OVER AND COMPLETE OTHER SIDE OF FORM...............

PATIENT/GUARDIAN DECLARATION

I understand the above information is necessary to provide me /_______________________________________(“my ward”) with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

In order to provide you with the highest standard of dental care, this practice is required to collect personal details from you. Details such as, your name, address and necessary medical history regarding your health and past medical or surgical events. Without such information the treating dentist is unable to plan your care properly. All information will be handled with the strictest confidentiality. All records that contain personal information shall not be disclosed to any person, body or agency other than the individual concerned, unless consented otherwise.

I hereby authorize the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my/my ward’s dental needs. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

PAYMENT TERMS AND CONDITIONS

1. “Dentist” means Dr Peter Nguyen Pty Ltd. “Patient” shall mean the person named as Patient on this Patient Registration Form or any person (or persons) that agree herein to be liable for the debts of the Patient on a principal debtor basis.

2. Time for payment for the services shall be of the essence and will be stated on the invoice. If no time is stated then payment shall be within seven (7) days of the invoice date. At the Dentist’s sole discretion payment shall be on delivery of the Service.

3. The Patient agrees that the Dentist may exchange information about Patient with those credit providers named in this Patient Registration Form or named in a consumer credit report issued by a reporting agency for the following purposes:
(a) To assess an application by Patient;
(b) To notify other credit providers of a default by the Patient;
(c) To exchange information with other credit providers as to the status of this credit account, where Patient is in default with other credit providers; and
(d) To assess the credit worthiness of Patient.

4. The patient consents to the Dentist being given a consumer credit report to collect overdue payment on commercial credit (Section 18K (1) (h) Privacy Act 1988).

5. The patient agrees that Personal Data provided may be used and retained by the Dentist for the following purposes and for other purposes as shall be agreed between the Patient and Dentist or required by law from time to time:
(a) Provision of Services;
(b) Analyzing, verifying and/or checking the Patient’s credit, payment and/or status in relation to provision of Services;
(c) Processing of payment instructions, direct debit facilities and/or credit facilities requested by Patient: and
(d) Enabling the daily operation of Patient’s account and/or the collection of amounts outstanding in the Patient’s account in relation to the Services.

6. The Dentist may give, information about the Patient to a credit reporting agency for the following purposes:
(a) To obtain a consumer credit report about the Patient: and/or
(b) Allow the credit reporting agency to create or maintain a credit information file containing information about the Patient.

7. If the Patient defaults in payment of any invoice when due, the Patient shall indemnify the Dentist from and against all the Dentist’s costs and disbursements including a solicitor and own client basis and in addition all of the Dentist’s nominees costs of collection.

8. THE PATIENT UNDERSTANDS AND AGREE THAT IF HE/SHE FAILS TO ATTEND AN APPOINTMENT WITHOUT GIVING 24HOURS NOTICE THAT HE/SHE WILL BE CHARGED A FAILURE TO ATTEND FEE.

9. By signing this Agreement you undertake to pay this account in full on or before the due date. In default of such prompt payment, you undertake to pay late payment fees of 2.5% per month on any amount outstanding and to indemnify us and pay all costs and expenses on a solicitor and own client basis if legal action is necessary, and/or any collection agency’s fees, which we may incur in recovering from you any overdue amount

I certify that the above information is true and correct. In accordance with the Privacy act (1988) I authorize any person or company to give information as may be required in response to credit inquiries. I have read and understand the **DECLARATION** and **PAYMENT TERMS AND CONDITIONS** and agree to be bound by these conditions.

If I execute this agreement as the person responsible for payment on behalf of the patient I guarantee the due and punctual payment of all monies payable under this agreement.

Patient/Guardian Signature____________________________ Date:_________________

Full name____