Garden Street Dental Surgery

36 Garden Street (PO Box 2266) Geelong 3220. Phone 52295811, Fax 52295030
Dr. Rohan Arora BDSc (Melb.) & Dr. Kathy Zandi BDSc (Melb.)
Arora and Zandi Pty Ltd. ABN 19 115 965 510

Surname:.. Title: Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Dr ❑ Other ❑

Other Names:.. Date of Birth:...

Home Address: .... Business Address:...

....................................P/Code: ....P/Code: ....

Ph:...............................Mobile: .... Ph:....................................Fax: ....

Postal Address (if different to above):...

Emergency Contact:...

Medical Doctor:... Ph:...

Do you have private dental insurance? If yes, which fund?………………………………………………………………

Who recommended you to this practice?………………………………………………………………………………

Are you unhappy with your 'smile?' If yes, why?...

PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY
HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES

	NO	YES		NO	YES
Rheumatic Fever	❑	❑	Hepatitis	❑	❑
High Blood Pressure	❑	❑	Asthma	❑	❑
Heart Ailment	❑	❑	Tuberculosis	❑	❑
Heart Murmur	❑	❑	AIDS / HIV	❑	❑
Heart Attacks	❑	❑	Excessive bleeding eg Haemophilia	❑	❑
Stroke	❑	❑	Radiotherapy or Chemotherapy	❑	❑
Diabetes	❑	❑	Thyroid Disease	❑	❑
Kidney or Liver Disease	❑	❑	Epilepsy	❑	❑

List any other previous illnesses/operations/hospitalizations: ....
....

	NO	YES
Do you have: an artificial hip, heart valve or other prosthetic implant?..	❑	❑
Has your doctor advised you to have antibiotics before dental treatment?....................................	❑	❑
Have you ever had problems with dental treatment?..	❑	❑
Are you at risk of Creutzfeldt-Jakob disease (Mad Cows Disease) ? For example, known or suspected carriers, family history, recipients of human pituitary hormones (growth hormone or gonadotrophins), undiagnosed neurological illness, neurosurgery between 1972-1989..	❑	❑
Female patients, are you pregnant or breastfeeding?...	❑	❑
Do you have allergies?	❑	❑
Please list……		
Are you presently under medical care or taking any medicines or tablets?..	❑	❑
Please list……		
Have you ever been treated for osteoporosis or taken the medication 'Fosamax?'……………………	❑	❑

PLEASE ASK IF YOU ARE UNSURE IN RELATION TO ANY OF THESE QUESTIONS
PLEASE ADVISE IF ANY OF THIS INFORMATION CHANGES BETWEEN YOUR APPOINTMENTS
THANK YOU FOR YOUR ASSISTANCE

I have completed this Questionnaire understanding that failure to make a full disclosure may place ME at undue medical risk. I also understand that I must inform my dentist if there are any changes to my medical history in the future.

Signed:... Date:……………………………………………..

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Your Health Information - Privacy Consent Form

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

Our practice 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:

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 our services and any 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, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. 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 of 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.

5. If any of the information we have about you is inaccurate, you may ask us to alter 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 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.

Signed: ____
Date: ____
Patient/ Parent / Guardian Name:_______________________________________
Dependents:____

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