



# 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 \_\_\_\_\_ Date of Birth (生日) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Given Names (大名) \_\_\_\_\_

Surname (姓) \_\_\_\_\_

Address (地址) \_\_\_\_\_

Suburb (地區) \_\_\_\_\_ Post Code (郵遞區號) \_\_\_\_\_

Mobile ☎ (電話) \_\_\_\_\_ Alternative ☎ \_\_\_\_\_

Email: \_\_\_\_\_ Occupation (職業) \_\_\_\_\_

Who Referred You To The Endodontic Centre (轉診牙醫大名) :

Contact Details (轉診牙醫診所資料) \_\_\_\_\_

\_\_\_\_\_

**Emergency Contact Person** (緊急聯絡人) \_\_\_\_\_ Phone ☎ (電話) \_\_\_\_\_

Relationship (關係) \_\_\_\_\_ Guardian / Carer Name \_\_\_\_\_

## Please TICK the relevant responses (個人病史)

你曾經或現在有 :	Yes	No		Yes	No
Uncontrolled Asthma (未治療的哮喘)	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease (肝臟疾病)	<input type="checkbox"/>	<input type="checkbox"/>
History of Epilepsy (癲癇)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease (腎臟疾病)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (心血管疾病)	<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonate treatment (骨質酥鬆藥物)	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS (愛滋病)	<input type="checkbox"/>	<input type="checkbox"/>	看牙科需要術前一小時服用抗生素	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder (凝血疾病)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (糖尿病)	<input type="checkbox"/>	<input type="checkbox"/>

Other condition not listed above 其他 \_\_\_\_\_

Please give details for the following: (藥物史)

有沒有對任何東西過敏 \_\_\_\_\_

目前服用的固定處方藥物 \_\_\_\_\_

若有懷孕，請問預產期日期 \_\_\_\_\_

其他 \_\_\_\_\_

Endodontist check \_\_\_\_\_ Date: \_\_\_\_\_

# Privacy and Practice Policies

(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 healthcare professionals, or require it from them if, in our judgment, that is necessary for the context of your treatment with your consent. In that event, disclosure of your personal details will be minimised wherever possible.
- We may also use parts of your treatment information for research and teaching purposes. Some material may be presented in lectures or at seminars. The material will be de-identified and your identity will not be disclosed.
- 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 may apply in relation to the types of access you seek.
- 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 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.

All the accounts are payable on the day unless prior arrangements have been made. The Practice may institute any recovery processes, as the Practice in its discretion decides, at the Patient's cost and expense on an indemnity basis should the payment be delayed without prior approval.

By signing this form, you understand the privacy and practice policies and confirm that the information provided is true and accurate.

**(Derived from the ADAVB Inc 2002)**

**Signature** \_\_\_\_\_

Date:            /            /

**Print Name (Parent/Guardian)** \_\_\_\_\_