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: / /

Given Names:

Surname:

Address:

Suburb: Post Code

Mobile Alternative

Email: Occupation

Who Referred You To The Endodontic Centre:

Referring Dentist Detail

Emergency Contact Person Phone

Relationship Guardian / Carer Name

Please TICK the relevant responses

Do you have, or have you ever had:	Yes	No		Yes	No
Uncontrolled Asthma	☐	☐	Kidney Condition	☐	☐
History of Epilepsy	☐	☐	Bisphosphonate treatment	☐	☐
Heart Condition	☐	☐	Antibiotic Prophylaxis for Dental Tx	☐	☐
HIV / AIDS	☐	☐	Diabetes	☐	☐
Bleeding disorder	☐	☐	Risk of Mad Cow Disease	☐	☐
Liver Conditions	☐	☐	Fully COVID19 vaccinated	☐	☐

Other condition not listed above

Please give details for the following:

Do you have any **known allergy?**

Regular mediations you are taking

Please inform us if you might be **pregnant**

Any other relevant information you would like to add

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 health care 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 health 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 Patients cost and expense on an indemnity basis should the payment be delayed without prior approval.

By signing this form, you understand the privacy and the practice polices and confirm that the information provided are true and accurate.
(Derived from the ADAVB Inc 2002).

Signature _____ Date: / /

Print Name (Parent/Guardian) _____