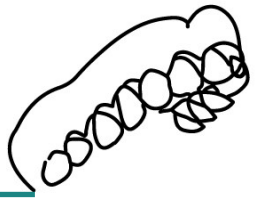
STARKEY**SMILES**

NEW PATIENT REGISTRATION



Welcome to Starkey Smiles Denture Care. Please take your time to complete the following information as accurately as possible. The information you provide will help with your treatment planning and assists in providing you with the professional service and care you deserve. If you have any questions are would like clarification do not hesitate to ask for assistance.

PERSONAL DETAILS		
First Name:	Surname:	Preferred Name:
Date of Birth:	Contact Number:	Would you like SMS appointment confirmation? Yes / No
Email:		
Address:	Suburb	Postcode
Please Indicate if any of the following apply to you; ○ Private Health Insurance ○ DVA ○ Seniors/Concession Card ○ QLD Health Voucher		
Preferred Dentist:		

MEDICAL HISTORY	**Please indicate if any of the following apply;**		
Asthma, chest or breathing problems	Yes / No	Stomach, bowel, digestive problems or ulcers	Yes / No
Anxiety or depression	Yes / No	Heart valve, hip or other prosthetic implant.	Yes / No
Blood disorder or excessive bleeding	Yes / No	Heart Problems, defects or pace maker	Yes / No
Cancer	Yes / No	Thyroid Problems	Yes / No
Diabetes	Yes / No	Hepatitis (Hep A, Hep B, Hep C)	Yes / No
Epilepsy	Yes / No	AIDS/ HIV	Yes / No
High blood pressure	Yes / No	Any Contagious diseases	Yes / No
Kidney Disease	Yes / No	Are there any personal medical conditions you wish to speak about in private?	Yes / No
Please list any known allergies or sensitivity's: E.g. Latex gloves			
Please list any medications you are currently taking:			

Entered:

PRIVACY CONSENT FORM

We require your consent to collect personal information about you.

Please read this information carefully and sign where indicated below.

Your Dental Prosthetist collects information from you for the primary purpose of providing quality dental health care. Your personal details and a full medical history are required so that we may properly assess, diagnose, treat and be proactive in your dental health care needs. This means we will use the information in the following ways;

- Administrative purposes in running the Denture Clinic, including billing.
- Health fund/ health insurance commission requirements.
- Disclosure to others involved in your dental health care, including treating doctors, dentists or other dental specialist outside this denture clinic. This may occur through referral to a doctor, dentist or dental specialist.

The records of each consultation will be maintained and referred to by your dental prosthetist in the management of an dental health problems that may arise.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this denture clinic has a privacy policy on handling personal patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the dental health treatment and care given to me and potentially place myself at risk.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately by withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other then as set out above, my further consent must be obtained.

I consent to the handling of my information by this denture clinic for the purpose set out above, subject to any limitations on access or disclosure that I notify this denture clinic of.

I consent to being included on the recall database of this denture clinic as detailed above.

Patient Name: _____

Patient Signature: _____ Date: _____

Do you consent to the taking of before & after photographs to document your treatment?

(These photographs will be limited in detail to include only from your nose to chin, and free from any personally identifiable characteristics) Yes / No

Would you like a copy of this document? Yes / No