PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

Ref: _____
(Office use only)

Name: _____

Address: _____

_____

Home No: _____ Work/Mobile: _____

What is the main concern with your teeth?

_____

_____

How have you come to us?
[ ] Dentist referral
[ ] Recommendation of family or friend Name: _____
[ ] Smile Council Website
[ ] Internet social network (eg. facebook, Twitter)
[ ] Radio
[ ] Newspaper Advertisement
[ ] Other _____

Are you coming for a second opinion? [ ] YES [ ] NO
Are you in orthodontic treatment currently? [ ] YES [ ] NO
Have you had orthodontic treatment previously? [ ] YES [ ] NO

Who is your family dentist?
NAME: _____

Street Address (if known): _____

Suburb _____

Have you had a dental check-up in the last 12 months? [ ] YES [ ] NO

If "NO", when was the last dental check-up? _____

Have your teeth or jaws ever been damaged in an accident? [ ] YES [ ] NO
Do you have painful, clicking or locking jaw joints [ ] YES [ ] NO

Have we treated any other members of your family? [ ] YES [ ] NO

NAME(S): _____

Relation to you? _____

Who will be responsible for the payment of fees?

NAME: _____

ADDRESS: _____

Specialist Orthodontists

Dr. Albert Wong M.D.Sc
Provider No: 0520867J

Dr. Samar Amari M.D.Sc
Provider No: 0561425H

Dr. Hong J Chan D.C.D
Provider No: 2370326Y

Dr. Alan Pollard M.D.Sc
Provider No: 0394375T

Dr. Merran Story M.D.Sc
Provider No: 0626689X

Dr. Katherine Georgalis D.C.D
Provider No: 2471969A

Offices

18 Scholar Drive
University Hill
Bundoora 3083

16 Doncaster Rd
Balwyn North 3104

Tel: 1300 733 077
Fax: 03 94738550

Mail

PO Box 2042
University Hill
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info@smilecouncil.com.au
www.smilecouncil.com.au

Smile Council Pty Ltd trading as
Smile Council Orthodontics
ABN 91 893 766 988

MEDICAL HISTORY

Ref: _____
(Office use only)

Patient: _____ Date of Birth: _____

Who is the family doctor? Name: _____

Address (if known): _____

Have you ever had any serious medical or surgical problem(s)? [ ] YES [ ] NO
If "YES", please provide details:

_____

Do you suffer from or has had any of the following? (If "YES", please tick)

[ ] Rheumatic fever	[ ] Heart disease / murmur	[ ] High blood pressure
[ ] Stroke	[ ] Rheumatism	[ ] Asthma - mild /moderate /severe
[ ] Diabetes	[ ] Fits / Epilepsy	[ ] Kidney disease
[ ] Hepatitis	[ ] Any blood disorder	[ ] HIV / AIDS
[ ] Osteoporosis	[ ] Heart disease / murmur	[ ] Joint problems / replacement
[ ] Disorder of the stomach / digestive system		

_____

Do you have any allergies? (eg. Latex, Medicines, Foods, etc) [ ] YES [ ] NO
If "YES", please provide details:

_____

Are you taking any medication? [ ] YES [ ] NO
If "YES", please provide details:

_____

Do you have any medical condition needing ANTIBIOTIC COVER before dental treatment?
[ ] YES [ ] NO
If "YES", please provide details:

_____

If female, are you pregnant? [ ] YES [ ] NO

Are you a smoker? [ ] YES [ ] NO

Are there any other medical or physical condition(s) we need to know about? [ ] YES [ ] NO
(Eg. Learning difficulty, Anxiety, Hearing impairment, Autism Spectrum Disorder, etc)
If "YES", please provide details:

_____

_____

Is there anything you would like to discuss with the doctor in private? [ ] YES [ ] NO

Please note that we can only treat you according to the information you have provided us. [ ] YES

Name: _____ (Patient/Guardian)

Signature: _____ 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 Orthodontist. 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: _____

Patient Name: _____

Patient ID (Office use only): _____

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