

**CAMBERWELL CHILDREN'S DENTISTRY**

Specialist Paediatric Dentists

**PATIENT'S IDENTIFICATION AND HISTORY - PLEASE PRINT USING BLOCK LETTERS**

Surname \_\_\_\_\_ First Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex **M / F** Home phone \_\_\_\_\_

Address \_\_\_\_\_ Suburb \_\_\_\_\_ Postcode \_\_\_\_\_

Parent's Name Ms/Miss/Mrs/Mr/Dr \_\_\_\_\_ Mobile \_\_\_\_\_

Occupation \_\_\_\_\_ Bus. phone \_\_\_\_\_

Parent's Name Ms/Miss/Mrs/Mr/Dr \_\_\_\_\_ Mobile \_\_\_\_\_

Occupation \_\_\_\_\_ Bus. phone \_\_\_\_\_

Parents are: married ( ) separated ( ) divorced ( ) widowed ( ) defacto ( )

Are there any custody or legal arrangements in place regarding the care of the above child? Yes / No

Person responsible for account \_\_\_\_\_ **Email Address.** \_\_\_\_\_

Address \_\_\_\_\_ Postcode \_\_\_\_\_

In case of emergency, name of nearest relative (not living at your address) \_\_\_\_\_

Address \_\_\_\_\_ Home phone \_\_\_\_\_

Patient referred by \_\_\_\_\_ General Dentist \_\_\_\_\_

**MEDICAL AND DENTAL HISTORY**

Please circle any of these conditions that the patient has had:

Rheumatic fever	Asthma	Hepatitis A B C	Operations/Hospitalisations
Heart disease/Murmur	Breathing difficulties	Diabetes	Birth defects
Kidney disease	Bleeding disorders	Food/Drug Allergy	Behavioural disorders
Epilepsy	Aids / HIV	Growth problems	Other Special Needs

Other conditions \_\_\_\_\_

Please give details of any of the above noted \_\_\_\_\_

What medication or drugs is the patient now taking? \_\_\_\_\_

Who brushes the patient's teeth?	Self (patient)	Combined parent-child	Parent
When is tooth brushing done?	Morning - before / after breakfast	Before bedtime	Everyday / Not Everyday

What dental problems has the patient had? \_\_\_\_\_

What is the reason for seeking dental care today? \_\_\_\_\_

On previous visits to the dentist, has your child been anxious? Yes / No If yes, please describe: \_\_\_\_\_

Have any teeth been extracted? Yes / No \_\_\_\_\_

If there have been any accidents involving teeth, please describe: \_\_\_\_\_

Do you belong to a Private Health Fund? Yes / No	If so, do you have Hospital Cover? Yes / No
Health Fund Name & Schedule _____	Do you have dental extras? Yes / No

Eligible for Child Dental Benefits Schedule? Yes / No If so, Medicare No. \_\_\_\_\_ (please include child's # on card)

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please note: Fees will be incurred if less than 24 hour's notice is given of cancellation of an appointment.

**PLEASE TURN OVER →**

## **YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY**

Our practice respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles. This statement is a brief summary of the practice's privacy policy. The complete policy is available on request.

Our practice, Camberwell Children's Dentistry ABN: 95 417 742 022, trading as Camberwell Children's Dentistry collects information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are 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 health care. We may collect information about you from third parties providing the collection of that information is necessary to provide you with health care.

We may disclose your health information to other health care professionals, or require it from them if, in our judgment, that is necessary in the context of your care.

We may also use parts of your health information for research purposes, in study groups or at seminars; however, in such situations, your personal identity will not be disclosed without your consent.

If you choose not to provide us with information relevant to your care, we may not be able to provide a service to you, or the service we are asked to provide may not be appropriate for your needs. Importantly, if you do not provide information that may be relevant to your care or that is otherwise requested by us, you could suffer some harm or other adverse outcome.

Your medical history, treatment records, x-rays and any other material relevant to your care will be stored by the practice. The practice privacy policy sets out how you can access your records or seek correction of your records.

The practice privacy policy sets out how you may complain about a breach of privacy and how the practice will deal with such a complaint.

As part of its electronic records system, the practice may rely on cloud storage providers located outside Australia. The practice will ensure that any offshore transfer complies with its obligations under Australian privacy laws.

The practice Privacy Officer can be contacted at the practice during business hours if you have any concerns or questions about a privacy matter.

Parent/Guardian please sign: \_\_\_\_\_

Date: \_\_\_\_\_