DEAR PATIENT

Please take your time to answer these questions as completely as possible. This will assist us greatly in our effort to provide the best dental treatment for you.

MR. MRS. MISS. MS. DR. SURNAME _____ FIRST NAME _____

ADDRESS _____ POSTCODE _____

TELEPHONE _____ DATE OF BIRTH _____ DAY _____ MONTH _____ YEAR

MOBILE _____ FAX _____

BUSINESS ADDRESS _____ TELEPHONE _____

EMAIL _____

OCCUPATION _____ NEAREST RELATIVE _____ TEL _____

MEDICARE NO _____ LICENCE NO _____

PERSON RESPONSIBLE FOR FEES _____ DO YOU HAVE DENTAL INSURANCE _____

WHICH FUND _____ WHEN WAS YOUR PREVIOUS DENTAL VISIT _____

WHO MAY WE THANK FOR RECOMMENDING YOU TO OUR OFFICE _____

PLEASE CIRCLE THE APPROPRIATE ALTERNATIVE

HAVE YOU HAD ANY SERIOUS HEALTH PROBLEMS IN THE LAST YEAR? (NO) (YES)

DO YOU TAKE ANY MEDICATION OR DRUGS REGULARLY? (NO) (YES)

HAVE YOU HAD ANY ADVERSE REACTIONS TO ANY TREATMENT OR MEDICATION? (NO) (YES)

DETAILS _____

PLEASE TICK BOX IF YOU HAVE SUFFEREED ANY OF THE FOLLOWING.

- ☐ HEART OR VASCULAR DISORDER
- ☐ BLOOD DISEASE OR BLEEDER
- ☐ BLOOD PRESSURE
- ☐ RHEUMATIC FEVER
- ☐ DIABETICS
- ☐ LIVER OR KIDNEY DISEASE
- ☐ ASTHMA
- ☐ EPILEPSY
- ☐ ALLERGY OR HYPERSENSITIVITY
- ☐ ARTHRITIS
- ☐ THYROID
- ☐ BRONCHITIS
- ☐ RADIOTHERAPY OR CHEMOTHERAPY
- ☐ PREGNANCY
- ☐ ARE YOU TAKING ANY MEDICATION FOR THE ABOVE

IS THERE ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DENTIST IN PRIVATE? (NO) (YES)

YOU HAVE A LEGAL DUTY TO TELL THE DENTIST IF YOU ARE CURRENTLY (INFECTIOUS) OR A CARRIER OF ANY DISEASE.

WHAT DENTAL PROBLEMS ARE YOU HAVING? PLEASE TICK

- ☐ TOOTHACHE
- ☐ SENSITIVE TEETH (HOT/COLD)
- ☐ BLEEDING GUMS
- ☐ LOOSENING TEETH
- ☐ MISSING TEETH
- ☐ UNSATISFACTORY DENTURE
- ☐ RAPIDLY DECAYING TEETH
- ☐ LOST FILLING - CAVITY
- ☐ GRINDING / CLENCHING OF TEETH
- ☐ WORN / BROKEN TEETH
- ☐ OBVIOUS SOUNDS FROM JOINTS
- ☐ PAIN IN FACE OR JAW JOINTS
- ☐ CHEWING IS DIFFICULT
- ☐ DISCOLOURED TEETH
- ☐ BAD APPEARANCE
- ☐ MOUTH ODOUR

FOR DENTAL TREATMENT DO YOU PREFER INJECTIONS? PLEASE TICK

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

HAVE YOU HAD ANY PROBLEMS WITH DENTAL INJECTIONS? (NO) (YES)

PLEASE GIVE DETAILS _____

I UNDERTAKE IN THE EVENT OF PAYMENT NOT BEING AFFECTED IN RESPECT OF ANY TREATMENT PROVIDED I AGREE TO PAY ANY AMOUNTS OWING TO DR. F. GALOUSTIAN INCLUDING ANY COSTS OF RECOVERY WHICH MAY BE INCURRED.

TODAY'S DATE _____ 20 _____ SIGNATURE _____

Health Funds & Private Insurance

We have no control or responsibility with regards to the benefits paid other than providing the Fund with the necessary information regarding the treatment that is being undertaken.

As a courtesy, we bill all health funds, however you are responsible for any charges your health fund does not pay. It is always best for you to contact them, to find out exactly what benefits you are entitled to, as they vary greatly amongst health fund plans.

Financial Policy & Payment Options

Payment is due at time service is rendered, unless prior financial arrangements have been made. We accept: Bankcard, MasterCard, Visa or American Express.

Please Note: Monthly instalment payments are available, and are not related to the number of visits during the treatment but are merely a way of spreading cost of treatment over the agreed time for your convenience. Payment is due on the first of every month if you choose to do instalment payments.

Any **overdue amount** will incur a statement fee of **$10 per month**.

Missed Appointments & Cancellation Policy

Failure to attend an appointment may delay progress in your treatment. If you are unable to attend an appointment, please notify us with **24 hrs notice** to avoid a missed appointment fee or a late notice **fee of $50.**

Orthodontic Records

Before starting treatment our first step is to take through records of your face and mouth. These records include x-rays, photographs of your face and teeth and moulds of your mouth. All records are studied to determine how your teeth and jawbone are positioned, and formulate a treatment.

Privacy & Treatment Consent

In accordance with the Commonwealth Privacy Act 1988, the Dental board of Australia's Code of Conduct for Health Care Practitioners, the Office of the Privacy Commissioner National Privacy Principles September 2001 and Health Care Complaints Commission (HCCC), Dental Council of NSW, Health Professional Council Authority (HPCA), Anti-Discrimination Board (NSW), NSW Office of Fair Trading, NSW Ombudsman: a patient can expect that their personal health and other information will be collected, used, disclosed and stored in accordance with relevant laws about privacy, and that this information will remain confidential unless the law allows disclosure or the patient directs us to release the information.

A patient will be informed what procedure is being proposed in addition to possible risks, benefits and alternatives to treatment. A patient will be afforded the opportunity to ask questions and receive answers in regards to the treatment proposed. The patient will be informed of cost of treatment and afforded the opportunity to communicate their decision to the dental practitioner.

Signature: _____Date: _____