Wyndham
Periodontics
Dental Implants

Confidential Medical History Questionnaire

Surname: ________________________________ Given Name: ________________________________

Title: Mr / Mrs / Ms/ Other: ____________________ Date of Birth: ________________________________

Address: ________________________________ Postcode: ________________________________

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Phone: ____________________ Mobile: ________________________ Work:____________________

Email address: ____

Occupation: ______________________________ Employer: ________________________________

Next of Kin: ______________________________ Relationship: ______________ Phone: ________________

Who is responsible for account? Self/WorkCover/TAC/DVA/Other, please specify ________________________

Do you have Private Health Insurance? Yes/No if yes which fund ______________________________

General Medical Health

Please circle any condition you have had or currently suffer.

Anaemia	Cancer	Arthritis	Diabetes
Blood Pressure	Cystic Fibrosis	Artificial Prosthesis	Epilepsy
Heart Disorder	Hepatitis A, B or C	Osteoporosis	Headaches/Migraine
Haemophilia	HIV/ AIDS	Spinal Problems	Kidney Disease
Pacemaker fitted	Liver Disease	Taking Bisphosphonates	Sinus Problems

If you have any other medical problems or known allergies not covered by this list please detail below;

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Your medical practitioner: ____

Suburb: ______________________________ Telephone: ________________________________

Have you been in hospital in the last year? Yes / No ________________________________

Have you ever had a blood transfusion or received blood products? Yes / No ____________________

Are you a smoker? Yes / No How many cigarettes would you smoke per day? ____________________

Females are you pregnant? Yes / No ____

Please list any medication that you may take on a regular basis

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We respect your privacy and will hold your responses in the strictest confidence.

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Your Health Information and Our Privacy Policy

In accordance with the Victorian Health Records Act 2001 and Privacy Act.

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 healthcare 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. 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 our 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 admission 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.

1. Payment in full required on day of treatment
2. The patient will accept full liability for Work Cover and TAC and legal claims which are reflected.
3. Accounts referred to a collection agency or Solicitor will have legal costs and commission added to the amount due.

Signed: ____

Date: ____

If Parent/Guardian

Signed: ____

Date: ____