DR. GILES A.J. PLUNKETT
BDSc (Melb), MDSc (Melb), LDS (Vic),
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Registered Specialist Orthodontist

34 Chesterville Rd, Cheltenham, VIC, 3192
t (03) 9583 0094 **f** (03) 9583 1155
e plunkettortho@tpg.com.au

PLUNKETT orthodontics

CONFIDENTIAL

PERSONAL DETAILS

Surname ..... Date of birth .....
Other names..... Your school, or occupation .....
Home address ..... Home phone.....
..... Work phone .....
Patient mobile ..... Patient email.....
Mother's name ..... Father's name .....
Mother's phone (BH) ..... Father's phone (BH) .....
Mother's mobile ..... Father's mobile .....
Person responsible for fees ..... Billing address .....
Responsible party email address.....
Do you have dental insurance? ❑ Yes ❑ No.....If yes, with whom? .....
Names of other family members treated here .....
Who recommended our practice to you? .....
Who is your family dentist?.....Date of last visit .....
What is your main concern or reason for this appointment?.....

MEDICAL HISTORY

Please tick if you have ever had any of the following:

❑ HIV / AIDS	❑ Diabetes	❑ Heart problems	❑ Speech/Hearing problems
❑ Arthritis	❑ Hepatitis	❑ Rheumatic fever	❑ Tonsil/Adenoid problems
❑ Asthma	❑ Allergic reactions	❑ Surgical operations	❑ Blood pressure problems
❑ Bleeding disorders	❑ Mood/Anxiety problems	❑ Epilepsy	❑ Bisphosphonate treatment

Please list any other serious illnesses, injuries, or issues we should be aware of.....
.....
Are you at present receiving medical attention, or taking any drugs or medication?..... ❑ Yes ❑ No
If yes, please give details .....
Ladies are you pregnant? If yes, when are you due? ..... ❑ Yes ❑ No

DENTAL HISTORY

Are you concerned about the appearance of your: ❑ Face ❑ Lips ❑ Teeth ❑ Smile ❑ Jaws
Have you ever had any previous orthodontic assessment or treatment?..... ❑ Yes ❑ No
If yes, please give details .....
Are you, or have you been a thumb sucker?..... ❑ Yes ❑ No
Do you have any functional problems biting or chewing your food? ..... ❑ Yes ❑ No
Have you ever had problems with your jaw joints (TMJ / TMD)?..... ❑ Yes ❑ No
Have you had any injuries to your face, teeth, or jaws? ..... ❑ Yes ❑ No
Have you had any difficulties or problems with dental treatment?..... ❑ Yes ❑ No
If yes, please give details .....

Signature of patient / parent ..... Date .....

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YOUR HEALTH INFORMATION – Privacy consent

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:

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, processing payments, writing to you about our services or any issues affecting your treatment and for debt collection purposes.

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.

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.

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 dentist. 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 the services.

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 name .....

Parent / guardian name.....

IMPORTANT NOTE

So we can serve you better, please advise us of any changes to your medical or dental history. Please also advise us of any change of address or other contact details, or change of your family dentist.

Thank you for helping us keep your health information current.