Your Health and Information and Our Privacy Policy

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 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, including specialists we may refer you to, or require it from them, if, in our judgement, that it 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 practice staff. Statutory fees will apply in relation to the type 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 be 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 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:____

Dependants:____

PATIENT HISTORY

FULL NAME: …………………………………………………………………………
Mr / Mrs / Ms / Miss / Master: (Please underline, preferred name)
AGE: ……………… Years ……………… Months Date of Birth / /
HOME ADDRESS: POST CODE:
POSTAL ADDRESS: POST CODE:
TELEPHONE: Home: Work: Mobile:
EMAIL ADDRESS:
PRIMARY / HIGH SCHOOL / COLLEGE attending:
or OCCUPATION:

PARENT DETAILS: (if patient is under 18 years)
FATHER:
FULL NAME:
ADDRESS (as above / other):
OCCUPATION: Work Ph:

MOTHER:
FULL NAME:
ADDRESS (as above / other):
OCCUPATION: Work Ph:

PARTY RESPONSIBLE FOR FEES: Self / Father / Mother / Other:
ACCOUNT NAME / S:
(to sign for authority and authorisation overleaf)
NAME OF PRIVATE HEALTH FUND / INSURANCE CO:
FAMILY DENTIST:
FAMILY MEDICAL PRACTITIONER:
SCHOOL DENTIST:
SCHOOL DENTAL CLINIC:
WHO REFERRED YOU TO US?

PREVIOUS ORTHODONTIC HISTORY:
CONSULTATIONS:
TREATMENT (eg Plates / Braces):
EXTRACTION OF TEETH:

HABITS:
Please read and cross out that which does not apply:
MOUTH BREATHING: Always / Sometimes / Never
NOSE BREATHING PROBLEMS: Yes / No
THUMB / FINGER SUCKING: Never / Current / Given up at age years.

MEDICAL HISTORY

ALL INFORMATION WILL BE TREATED WITH PROFESSIONAL CONFIDENTIALITY

HAVE YOU SUFFERED ANY SERIOUS ILLNESSES? (Yes / No)
If Yes, Details of Illness:

HISTORY OF ADVERSE REACTION TO TREATMENT OR MEDICATION? (Yes / No)
DO YOU HAVE AN ALLERGY TO LATEX (Yes / No)
METALS (Yes / No)
MILK PROTEINS (Yes / No)
BISULPHATES (Yes / No)

DO YOU HAVE OTHER ALLERGIES? (Yes / No)
If Yes, details of allergies)

DO YOU TAKE DRUGS / MEDICATION REGULARLY? (Yes / No)

ANY INJURIES / OPERATIONS IN THE HEAD OR NECK AREA?(Yes / No)

DO YOU HAVE ANY BLEEDING PROBLEMS OR HEART CONDITIONS? (Yes/No)
DO YOU HAVE A PACEMAKER? (Yes / No)

DO YOU NEED PROPHYLACTIC ANTIBIOTIC COVER FOR DENTAL TREATMENT? (Yes / No):

HAVE YOU BEEN TESTED FOR HIV/HEPATITIS B OR HEPATITIS C (Yes/No)
IF TESTED, WAS THE RESULT POSITIVE? (Yes/No)

SIGNATURE: ………………………………………………………………
Parent / Guardian / Self

TODAY'S DATE: ……………DAY…………….MONTH…………YEAR

It is important that you let staff know of any changes to your medical history that may arise during treatment and ask you to inform the orthodontist in regards to any medications being taken as some medications can affect saliva flow and dental health.

AUTHORITY AND ACKNOWLEDGMENT

To:

Dr Helen D. McLean

I/WE…………………………………………."The Parent(s)" / "Self"

HEREBY AUTHORISE you to provide orthodontic services to my / our child /

myself……………………………..”The Patient”

as you consider necessary or desirable and as agreed to by myself / ourselves. I / We hereby agree to be responsible for the payment of your professional fees for such services.

"In the case where both parents or guardians of the patient sign this form it is hereby acknowledged and agreed by such parents or guardians that they accept and undertake joint and several liability for the professional fees and expenses of, and incidental to, the dental services rendered, not with standing whether the account for such fees is in one or both names of such parents or guardians".

TODAY'S DATE………………………………………….

……………………………………………………
SIGNATURE OF PATIENT / PARENT OR GUARDIAN