CANE TO COAST DENTURES

PATIENT ASSESSMENT

In order to provide dental treatment of a high standard,
it is necessary to have the following information provided which will be handled confidentially:

DATE ……/……/……

NAME (Surname): ……(Given Names)……

ADDRESS: ……**AREA CODE**……

TELEPHONE: (Business): ……(Private): ……(Mobile): ……

OCCUPATION: …… **DATE OF BIRTH**:……/……/……

EMAIL ADDRESS: ……

PATIENTS DOCTOR: Name ……**PATIENTS DENTIST**: Name……

How did you hear about us? ……

Are you in a health fund for dental? YES / NO If so which fund:……..Patient No…….

Are you covered by Veterans' Affairs (DVA)? YES / NO Number:……..

Are you a Pensioner? YES / NO

Do you give permission for photographs of your teeth to be taken and displayed in this practice: YES/NO

SPECIFIC MEDICAL CONDITIONS: **Please answer each question.**

Heart Condition	Yes / No	Hepatitis / A.I.D.S (self or family)	Yes / No
Blood Pressure	Yes /No	Arthritis	Yes / No
Osteoporosis	Yes /No	Asthma	Yes / No
Cardiac Surgery / Pacemaker	Yes / No	Radiotherapy/Chemotherapy	Yes / No
Diabetes	Yes /No	Tuberculosis	Yes /No
Epilepsy	Yes /No	Mental/Physical Disability	Yes/No
Pregnancy	Yes/No		

How many sets of dentures have you owned: ……

How old are your current dentures? …… years.

ALLERIGIES:……

SOCIAL HISTORY: (Alcohol)…… (Smoker)……

RECENT MEDICATION:……

COMMENTS: ……

……

Please read and SIGN the back of this form

Phone: 07 **4943 2299** Email: **admin@canetocoastdentures.com**
70 Broad Street Sarina, Q, 4737
ABN 95 056 532 506

Privacy Consent Form

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Your **Dental Prosthetist (DP)** collects information from you for the primary purpose of providing quality dental health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your dental health care needs. This means we will use the information in the following ways:

- **Administrative purposes in running this Denture Clinic, including billing.**
- **Health Fund / Health Insurance Commission requirements.**
- **Disclosure to others involved in your dental health care, including treating doctors, dentists or other dental specialists outside this practice.**
  This may occur through referral to a doctor, dentist or dental specialist.

The records of each consultation will be maintained and referred to by your DP in the management of any dental health problem that may arise.

I have read the information above and fully understand the reasons why my information is required. I am also aware that **this Denture Clinic** has a privacy policy on handling personal patient information.

I understand that I am not obliged to provide and information requested of me, but that my failure to do so may compromise the quality of the dental health treatment and care given to me and potentially place myself at risk.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than as set out above, my further consent must be obtained.

I consent to the handling of my information by this Denture Clinic for the purpose set out above, subject to any limitations on access or disclosure that I notify this Denture Clinic of.

I consent to being included on the recall database of this Denture Clinic, as detailed above.

Patient Name: .....

Patient Signature: ..... **Date:** .....

You are welcome to a copy of this document. If you require a copy approach the front desk and place your request.