Frankston Endodontic Surgery
ABN 79 718 965 911

Dr C. Lindner MDSc (Melb.) MRACDS (Endo)
Registered Specialist Endodontist

Legal Surname: ....
Legal Given Name/s: ....
Preferred Name: .... Title: Mr Master Mrs Ms Miss Dr
Date of Birth (DD/MM/YYYY): ....
Parents/Guardians Name/s (if under 18): ....
Home Address: ....
.... Post Code: ....
Postal Address (if different to above): ....
Home Ph: .... Email: ....
Mobile: .... Work Ph: ....
Work Name and Address: ....
.... Post Code: ....
Name of Person responsible for Fees (please specify if **DVA**, **TAC**, etc.): ....
Do you have Private Health Insurance for dental? ....
Emergency Contact and their relationship to you: ....
.... Ph: ....
Medical Doctor: .... Ph: ....
Dentist who Referred you here: .... Ph: ....

CONFIDENTIAL

Health Summary

To the best of your knowledge, do you have or have you suffered from the following?

	YES	NO		YES	NO
High blood pressure	☐	☐	Artificial joint	☐	☐
Heart disease	☐	☐	Cancer	☐	☐
Prosthetic heart valve	☐	☐	Do you smoke?	☐	☐
Rheumatic fever	☐	☐	Gynaecological problems	☐	☐
Asthma or other respiratory problems	☐	☐	Immunity problems	☐	☐
Diabetes	☐	☐	Infectious diseases e.g. MRSA/VRE/STD/HIV	☐	☐
Thyroid problems	☐	☐	Stomach or bowel problems (ie ulcer)	☐	☐
Hepatitis or liver disease	☐	☐	Urinary/kidney disease	☐	☐
Excessive bleeding or blood disorder	☐	☐	Dementia or Alzheimer's	☐	☐
Stroke	☐	☐	Neurological problems	☐	☐
Back or neck problems	☐	☐	Epilepsy	☐	☐
Bone disease	☐	☐	Mental health/psychology	☐	☐
Osteoporosis	☐	☐	Anxiety	☐	☐
Broken bones	☐	☐	Do you have hearing aids/hearing difficulties?	☐	☐
Arthritis or Joint problems	☐	☐	Other	☐	☐

	YES	NO	
Have you ever had any serious problems after dental treatment?	☐	☐	
Are you taking any medicines, drugs, tablets or natural therapies? (Please list **ALL**)..........................	☐	☐	

....
....
....

Do you have any allergies or adverse reactions? (Please list **ALL**, including allergies to medicines or products such as Penicillin or Latex)..........................	☐	☐	

....

If applicable, are you pregnant? (If yes, how many weeks?)	☐	☐	☐NA

I have completed the above questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue risk.

Signed.. Date..........................

PLEASE NOTE THAT ALL FEES ARE TO BE PAID AT EACH APPOINTMENT
Please note that changes to appointments with less than 2 weekdays notice will incur a fee
P.T.O.

Your Health Information and Our Privacy Policy

Our practice respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles. This statement is a brief summary of the practice's privacy policy. The complete policy is available on request.

Our practice Frankston Endodontic Surgery (ABN 79 718 965 911) collects information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are 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 health care. We may collect information about you from third parties, providing the collection of that information is necessary to provide you with health care.

We may disclose your health information to other health care professionals, or require it from them if, in our judgement, it is necessary in the context of your care.

We may also use parts of your health information for research purposes, in study groups or at seminars; however, in such situations, your personal identity will not be disclosed without your consent.

If you choose not to provide us with information relevant to your care, we may not be able to provide a service to you, or the service we are asked to provide may not be appropriate for your needs. Importantly, if you do not provide information that may be relevant to your care or that is otherwise requested by us, you could suffer some harm or other adverse outcome.

Your medical history, treatment records, x-rays and any other material relevant to your care will be stored by the practice. The practice privacy policy sets out how you can access your records or seek correction of your records.

The practice privacy policy sets out how you may complain about a breach of privacy and how the practice will deal with such a complaint.

As part of its electronic records system, the practice may rely on cloud storage providers located outside Australia. The practice will take reasonable steps to ensure that any offshore transfer complies with its obligations under Australian Privacy Principles.

The practice Privacy Officer can be contacted at the practice during business hours if you have any concerns or questions about a privacy matter.

Please sign this form as confirmation that you have read and understood the above information and consent to the collection and use of your health information.

After reading both sides of this document, I have completed the above questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above details to send me appointment check-up reminders.

Signed:..**Date**:..............................

PLEASE PRINT NAME:..

Please circle: Patient Parent Guardian

If applicable:
Dependent (Patient Name):..

PLEASE NOTE THAT ALL FEES ARE TO BE PAID AT EACH APPOINTMENT

Please note that changes to appointments with less than 2 weekdays notice will incur a fee