

Mr. Mrs. Miss. Ms. Other: **D.O.B.** / /
 Surname: First Name: Middle Name:
 Preferred Name: Occupation:
 Home address:
 Suburb Post code
 Phone H () W () Mob
 E-Mail @
 Do you belong to a private health fund: Which Fund?
 Membership number: Ref No.:
Referral Source: Dentist Flyer Online Other

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

(In order to provide you with the best dental care, we require a sound knowledge of your general health)

Question	Check box if YES	Question	Check box if YES
1. Have you ever had any type of heart disease, heart murmur, or rheumatic fever? (Please Specify) <input type="text"/>	<input type="checkbox"/>	11. Do you or any members of your family have a history of Creutzfeldt-Jacob Disease (CJD)?	<input type="checkbox"/>
2. Have you ever had heart valve or a pacemaker? (Please Specify) <input type="text"/>	<input type="checkbox"/>	12. Do you have any bleeding problems or blood disorders? (Please Specify) <input type="text"/>	<input type="checkbox"/>
3. Have you ever had a stroke?	<input type="checkbox"/>	13. Women only: Are you pregnant? No of months <input type="text"/>	<input type="checkbox"/>
4. Are you allergic to any tablets or medicines? If yes, please list: <input type="text"/>	<input type="checkbox"/>	14. Do you have an infectious disease or liver problem? (Please Specify) <input type="text"/>	<input type="checkbox"/>
5. Have you ever had fits or epilepsy?	<input type="checkbox"/>	15. Do you have any Joint Problems, Arthritis or Joint Replacement Surgery? (Please Specify) <input type="text"/>	<input type="checkbox"/>
6. Do you have diabetes? <input type="checkbox"/> Type I <input type="checkbox"/> Type II		16. Do you have any other medical problems? If yes, please list: <input type="text"/>	<input type="checkbox"/>
7. Do you smoke? Number per day <input type="text"/>	<input type="checkbox"/>		
8. Have you ever had Tuberculosis, Asthma, or any other Lung Disease? (Please Specify) <input type="text"/>	<input type="checkbox"/>	17. Name and phone number of your General Dentist: Name: <input type="text"/> Phone No: <input type="text"/>	
9. Have you ever undergone a test for HIV (the AIDS virus)? Do you have any reason to believe you may have been exposed to the virus?	<input type="checkbox"/> <input type="checkbox"/>	18. Name and phone number of a person to contact in case of an emergency Name: <input type="text"/> Phone No: <input type="text"/>	
10. Please list any medications that you have taken in the last month? <input type="text"/>			

1. Payment is required at the completion of each treatment segment.
2. The patient accepts full liability for WORKCOVER and TAC claims that are rejected.
3. Accounts referred to a Collection Agency or Solicitor will have all legal costs and commissions added to the amount due.
4. Failing to attend, reschedule or cancel appointments with LESS than 48 hours notice will attract a fee of \$260 per scheduled hour charged to the patient.
5. The patient who has previously failed to attend, reschedule or cancel appointments with less than 48 hours notice will have to pay a deposit to re-book the appointment. This will be half (50%) of the proposed treatment segment cost.



Patient's signature _____ Date / / 2026

P.T.O

YOUR HEALTH INFORMATION - PRIVACY CONSENT FORM

Our practice respects your right to privacy, and it has systems and processes in place to ensure it complies with the Australian Privacy Principles (APPs). The practice privacy policy is available on request.

Our practice Dr Boris CHERKASSKI trading as MDS Manningham Dental Specialist 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 ensure that any offshore transfer complies with its obligations under the APPs.

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.

Signed: _____

Date:

Patient/ Parent / Guardian Name:

Dependents: _____