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Jeff Lipshatz ORTHODONTIST

New Patient Registration Form

Patient surname

Patient first name

Patient preferred name (if different)

Title

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Date of Birth

Age

Gender

☐ Male ☐ Female

Referred by

☐ Dentist ☐ Family / friend ☐ Internet ☐ Other

Name of person who referred you (if applicable)

CONTACT DETAILS

Street address

Suburb

State

Postcode

Email address

Home phone

Work phone

Mobile phone

Emergency contact name

Relationship to patient

Contact number

PERSON RESPONSIBLE FOR PAYMENT

Please tick appropriate box

☐ Self ☐ Parents ☐ Mother

☐ Father ☐ Other

if other, please specify

Name

Postal address (if different from patient contact details)

Suburb

State

Postcode

Email address

IF APPLICABLE

School /University

Sports / Hobbies

Parent/Guardian full name

Additional Parent/Guardian full name

MEDICAL HISTORY

Please check any of the following that are applicable

- ☐ Adenoid removal
- ☐ AIDS
- ☐ Asthma
- ☐ Bone disorder
- ☐ Cold sores/herpes
- ☐ Diabetes
- ☐ Endocrine problems
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting
- ☐ Heart condition
- ☐ Hepatitis
- ☐ Rheumatic fever
- ☐ Tonsil removal
- ☐ Other

More information (if applicable)

Current medications

Allergies

DENTAL HISTORY

Please check any of the following that are applicable

- ☐ Past injuries to the face
- ☐ Teeth grinding
- ☐ Thumb or finger sucking
- ☐ Extra or missing teeth
- ☐ Mouth breathing

More information (if applicable)

Does patient desire treatment? ☐ Yes ☐ No

Have other family members had orthodontic treatment? ☐ Yes ☐ No

Has an orthodontist been consulted previously? ☐ Yes ☐ No

OTHER INFORMATION

Current Dentist

Dentist contact number

Current Medical GP

Medical GP contact number

Private Health Insurer

Private Health Insurance membership number

DECLARATION

I have completed this questionnaire to the best of my knowledge and commit to advising the staff at Dr Lipshatz if there are any changes to the above information. I understand that notes, radiographs or models relating to treatment may need to be sent to other specialists and consent to this. I also give permission for the above contact details to be used for correspondence from Dr Lipshatz regarding appointments, accounts, information about the Practice, special offers and promotions.

Patient / Parent / Guardian Name

Signature (please type your name if submitting electronically)

Date

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YOUR HEALTH INFORMATION – PRIVACY CONSENT FORM

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:

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, 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.
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 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 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 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.

Patient / Parent / Guardian Name

Signature (please type your name if submitting electronically)

Date

Thank you for completing this Questionnaire and Privacy Consent Form.

Please click the "Submit Form" button to send the completed form as an email attachment to admin@jefflipshatz.com.au. Alternatively print out your completed form and bring it with you to your first appointment.

We look forward to seeing you in our practice soon!

To send us your completed form please click submit form. Your form will be automatically saved as a PDF and then added to an email in your preferred email program, all you need to do is click send!

If nothing happens when you click the submit form button please save your completed form to your desktop and send to us via email, or print out and bring with you to your first appointment.

Submit Form

Jeff Lipshatz Orthodontist
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Please visit our website jefflipshatz.com.au and find us on facebook for more information.

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