



NOTICE FOR PATIENT INFORMATION

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 (APPs). The practice privacy policy is available on request.

Our practice RYCHO Family Pty Ltd, ABN: 83 702 919 715 trading as White Light Prosthodontics 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.

Date:.....Patient/Guardian Name:.....Signed:.....

PATIENT HISTORY QUESTIONNAIRE

Dr/Mr/Mrs/Ms/Master/Miss
(Please Circle)

Patient's Full Name:

Preferred Name: **Date of Birth:** **Mobile:**

Ph Home:

Ph Work:

Email: randeep.sroya152@gmail.com

Address: **Post Code:**

Health Insurance Fund? Member No: Prefix:

Person responsible for fees? Occupation?

Who is your General Dentist? Who is your Medical Practitioner?

What is the reason for this consultation?

Who recommended you attend this Dental Practice?

Would you like to receive an Appointment reminder? (Please Circle) Yes No ... Preferred Method: Email SMS Mail ...

Department of Veterans Affairs' Card Number?

If you are under 18yrs please state Father/ Mother/ Guardian's name:

If Relevant, Guardian's name: Phone:

Emergency Contact Name: Ph Mobile

Recently travelled overseas? Yes ... No If Yes, please list locations COVID-19 vaccinated? ... Yes ... No

MEDICAL HISTORY: PLEASE CIRCLE THE RELEVANT RESPONSE:

Any Serious Illnesses Yes No Heart Murmur Yes No

An Operation or Anaesthetic Yes No Persistent Chest Problems Yes No

Epilepsy / Fits / Blackouts Yes No Asthma Yes No

Heart / Vascular Disorder Yes No Hepatitis or Jaundice Yes No

Blood Pressure Problems Yes No Kidney Disease Yes No

Rheumatic Fever Yes No Diabetes Yes No

Ladies: Are you Pregnant? Yes No Do you Snore Yes No

Are you taking any medications? If Yes, please list

Allergies or reactions to medications? If Yes, please list

The viruses causing HIV, Aids and Hepatitis B can be transmitted through blood and saliva. For the protection of yourself, other patients and staff, please advise if you have ever had any infectious disease or if you might be one of the recognized risk groups. Your treatment will not be affected as universal precautions are used in this practice. Confidentiality of discussions is assured.

Please assist us in this endeavour by ticking one of the following:

I AM NOT in a "High Risk" Category ☐

I COULD BE in a "High Risk" Category ☐

I wish to discuss this in private ☐

Please take care to fill out this form completely. We rely on all your information to be able to provide you with appropriate dental services.

Privacy Policy: We collect the information set out above in order to provide you with dental services. We will keep your information secure and confidential. If necessary, we may pass your information on to other health practitioners for a second opinion or referral purposes. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Date Signature Sighted by Dr.

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