



NENI'S DENTAL GROUP

IN ORDER FOR THIS DENTAL PRACTICE TO PROVIDE THE HIGHEST STANDARD OF CARE, IT IS REQUESTED THAT YOU FILL THIS FORM CAREFULLY AND THOROUGHLY

Mr/Mrs/Miss/Ms/Master Surname _____ Given Names _____

Date of Birth _____ Sex M/F Occupation _____

How did you find us? (please circle) Website/Google Newspaper Radio Family/Friend Other _____

Do you have a previous Dentist? _____ Last visit? _____

Mobile _____ Home _____ Work _____

Home Address _____ Suburb _____ Postcode _____

Postal Address (if different from above) _____ Suburb _____ Postcode _____

Email _____

Private Health Fund _____ Ref. No. _____ Veteran Affairs? Y/N DVA No. _____ Expiry _____

Name of person responsible for fees, if not yourself _____ Phone _____

Address _____ Suburb/Postcode _____

Emergency Contact _____ Relationship _____ Phone _____

Name of Medical Practice/Practitioner _____ Contact Number _____

Have you had an previous problems with dental treatment? Yes/No Are you currently under medical care? _____

Are you currently pregnant? Yes/No/Unsure If yes how many months? _____

Are you allergic to latex and/or have sensitivity to latex or rubber products Yes/No Allergic to Penicillin? Yes/No

Other allergies? _____ None Known

Have you ever been hospitalised? Yes/No Reason _____

Do you have/Have you had any of the following: Please tick Yes or No, Circle Type

	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			High Blood Pressure			Asthma			Bad Reactions To:		
Heart Disease			HIV			Tendency to faint			Local Anaesthetic		
Heart Surgery			Jaundice			Difficult Extractions			General Anaesthetic		
Chest pains			Diabetes Type I/II			Radiation Therapy			Are you taking any of the following?		
Lung Disease			Hepatitis Type			Bruise easily			Antibiotics		
Thyroid Disease			Epilepsy			Hip/Knee Replacement			Anticoagulant (Blood Thinners)		
Kidney Disease			Swollen Ankles			Organ Transplant			Steroids		
Liver Disease			Arthritis			Excessively Nervous			Bisphosphonates		
Blood Disorder			Sinus Troubles						Medication for Osteoporosis		
						Do you smoke?			How many?		

Other Medications _____

I have completed this questionnaire to the best of my knowledge and understand failure to make a full disclosure may place me at undue medical risk. I understand that notes, x-rays or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment.

I agree to be responsible for the full payment of my account on the day of my treatment. I agree, in the event that I am unable to pay my fee and it is referred to a debt collection agency that charges commission on a contingency basis, I shall be liable to pay a liquidated debt, the commission payable by the practice to the agency, fixed at the rate charged by the agency from a time to time as if the agency has achieved one hundred percent recovery and the following formula shall apply.

$$Commission = \{original\ debt\ 100 - commission\ \% \text{ charged by the agency (including GST)}\} \times 100$$

I give my permission for the practice to use the above details to contact me.

Patient/Parent/Guardian Name _____ Signature _____ Date _____



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HIV/AIDS Related and/or infectious disease

This clinic takes the precautions deemed necessary and recommended by Medical and Dental Authorities to prevent the spread of HIV infection and infectious disease. We expect all patients to inform their Dentist of any potential risk that they are aware of.

Cancellation and Failure to Attend Policy

Failing to attend or late cancellation of an appointment without **72 Hours notice** will incur a missed appointment fee of **\$250—\$400** based on the time allocated to you.

It is important to remember that your appointment is booked specially for you.

Our staff confirm appointments 72 hours before to avoid this so please let them know if you can no longer keep your allotted time, so it can be given to someone else.

Signature _____ Date _____

Privacy Consent Form

Our practice respects your rights 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 may 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, 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 it is necessary or relevant to your treatment, in that event, disclosure of your personal details will be minimized where possible.
3. 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 explanation of our records or a written summary, usual fees will apply for these services.
4. 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 upmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice without your prior consent. If you have any further questions or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

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.

Signature _____ Date _____

Patient/Parent/Guardian Name _____

Dependant(s) _____

Neni's Midnorth Dental Centre	08 8633 1400	52 Ellen Street Port Pirie 5540	nmde52@gmail.com
Neni's Tanunda Dental Centre	08 8563 2743	42a Murray Street Tanunda 5352	ntdc42@gmail.com
Neni's Renmark Dental Centre	08 8586 6651	131 Ral Ral Avenue Renmark 5341	nrdc131@gmail.com
Neni's Nuriootpa Dental Centre	08 8562 1093	17 Gawler Street Nuriootpa 5355	nmde@gmail.com
Neni's Dental Centre	08 8641 0077	16 Mackay Street Port Augusta 5700	npadc16@gmail.com