

WSND logo

Registration Form and Confidential Medical Questionnaire

Surname: Given Name:
Title: Mr/Mrs/Ms/Other Date of Birth:
Address:

Best contact numbers:
Phone: Mobile:
Name of contact person (if different to patient):

Next of Kin: Relationship:
Phone:

Who is responsible for the account?
Self/WorkCover/TAC/DVA/Other, please specify

Do you (patient) have private health insurance? Yes/No. If yes, which fund

Who has referred you to WSND? Self/Dentist/Doctor/Other, please specify

General Health

(as per list provided by Wyndham Periodontics)

PLUS: Psychiatric condition

Anxiety

Autism Spectrum Disorder ** (see additional info which would be appreciated)

Do you have any allergies? Yes/No. If yes, please specify

If you have any other medical or developmental conditions or disabilities, please detail below (or attach a medical summary from your medical practitioner)

Your medical practitioner:
Address: Phone:

Have you been in hospital in the last year? Yes/No

Are you a smoker? Yes/No

Females, are you pregnant? Yes/No

Please list any medications taken on a regular basis or attach a copy of your treatment sheet/drug chart

Your Health Information and Our Privacy Policy
In accordance with the Victorian Health Records Act 2001 and
Privacy Acts 2000 (Vic), 1988 (Commonwealth)

(As per information from Wyndham Periodontics)

? Can have this info as a link ?

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.

1. Payment in full is required on the day of treatment, where possible.
2. Accounts referred to a collection agency or solicitor will have legal costs and commission added to the amount due.
3. A cancellation fee may be applied for cancelling an appointment at short notice (within 2 hours) or failing to attend the appointment without notice.

Signed:

Self / alternative person responsible for the account (Name: _____)

If consent for dental examination is being given by a 'person responsible' (see OPA website <http://www.publicadvocate.vic.gov.au/medical-consent/when-a-patient-cannot-consent-to-treatment>)

Please sign below

Signed:

Relationship:

Name:

Date:

Please note: The dental examination may include cleaning and xrays.
Further treatment will require additional consent.

**** Additional info, which we would appreciate for individuals with ASD or other conditions, which require extra management strategies:**

- Any information about the individual's personality and strengths
- A list of things that are motivating for the individual (eg toys, iPad, praise)
- Anything that might alarm or frighten the individual (eg loud noises, bright lights)
- The strategies that can be used to calm the individual if upset
- Anything else you think might be useful for us to know (eg what the communications skills are like, whether the individual may try to run away, what the individual's capacity to wait is like)