

REGISTRATION FORM

Patient Details					
Given names			Surname		
Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other:		Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	
Date of Birth					
Address					
Telephone/mobile			Email		
Additional contact details					
Medicare number			DVA/Pension/Healthcare card no.		
<input type="checkbox"/> DVA Gold Card Holder <input type="checkbox"/> Private Health Insurance					
Any dental benefits?		Fund Name:		ID/membership number:	
				Series Number:	
<i>Please note our practice is not a preferred provider for any Health Insurance fund and does not bulk bill, therefore there will be out of pocket expenses. We also do not participate in the Child Dental Benefits Scheme.</i>					
Who referred you to our practice?					
Are you having problems with your teeth?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Details	

Dental/Medical Consent					
Who gives consent? <input type="checkbox"/> Self-consent (patient) <input type="checkbox"/> Appointed medical attorney <input type="checkbox"/> Next of kin <small>*Please note: paid carers or service providers cannot give consent</small>					
Name		Relationship to patient			
Address			Postcode		
Email			Contact number		
By signing the form below, you consent to the following: <input type="checkbox"/> I give consent for the patient (named above) to have a dental examination (which may include cleaning and x-rays) and understand I will be contacted about any additional treatment required. <input type="checkbox"/> I give consent for the dental/medical records for the patient (named above) to be released to the All Ability Dental Team and for us to be able to speak to their other health care providers and support workers as necessary. <input type="checkbox"/> I consent to the patient (named above) having clinical photographs taken if required. These photographs may be used for educational purposes in Special Needs Dentistry. No identifying images or information will be provided. <input type="checkbox"/> I consent to the use of email for communication of medical and dental information about the patient (named above). I understand that the All Ability Dental Team does not use end-to-end encrypted email and cannot guarantee the confidentiality of information sent by email. I understand that without the use of email, communication may be slower and some records (e.g. digital x-rays) cannot be sent.					
Sign		Date			
Financial Consent					
Name		Relationship to patient			
Address			Postcode		
Email			Contact number		
I agree to pay for any dental accounts generated during an oral examination (including cleaning and x-rays) or subsequent treatment. I understand I will be contacted if further treatment is required for additional consent. I understand I will remain responsible for payment incurred during the appointment unless I have given the practice at least 48 hours notice prior to the scheduled appointment time.					
Sign		Date			
<small>A cancellation fee will apply if we are not informed of the cancellation at least 24 hours prior to the scheduled appointment time. Dishonoured cheques will incur a fee. Payment in full is required on day of treatment except for patients who hold DVA Gold Cards or whose payment will be made by state trustee. Unpaid accounts of more than 30 days will be referred to a collection agency. All commissions and legal costs will be added to the amount due and paid by the financial consent person.</small>					