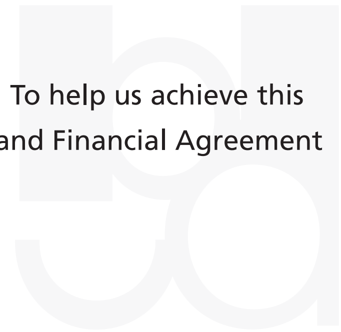

Our charter at **bc dental** is to provide you with the best possible care. To help us achieve this please complete and sign these Patient Registration, Medical History and Financial Agreement forms. All information is confidential.

Mr Mrs Miss Ms Dr Master

First name ______________________ Last Name ______________________

Date of birth ______________________

Address ______________________

Phone ______________ Mobile ______________ Work ______________

Email ______________________

Would you like a text message reminding you of your appointment? Yes No

If a child, please state Father/Mother/Guardian's name ______________________

Emergency contact ______________ Relationship ______________ Ph ______________

Medical Doctor ______________________ Ph ______________

Who is responsible for the account if not yourself? ______________________

Do you have private health insurance? Yes No Fund name ______________

Department of Veterans Affairs card number ______________________

### How did you hear about our dental practice?

Personal recommendation: If so, whom? ______________________

Walking past Google Internet Yellow Pages Other ______________

PRIVACY POLICY: We need the information set out above to provide you with effective and efficient dental services. You are entitled to access your information at any time and we will keep your information confidential. However, if necessary, we may forward your information to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

I agree to the terms stated herein.

Signature ______________________ Date ______________

## Have you had or do you currently have any of the following?

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| Heart conditions | YES | NO | Tuberculosis | YES | NO |
| Artificial joints (e.g. knee, hip) | YES | NO | Epilepsy | YES | NO |
| Tumours/Cancer | YES | NO | Creutzfeldt-Jakob disease | YES | NO |
| Hepatitis | YES | NO | Rheumatic fever | YES | NO |
| HIV positive | YES | NO | Venereal disease | YES | NO |
| Blood disorders (anaemia, etc) | YES | NO | Asthma | YES | NO |
| High/Low blood pressure | YES | NO | Latex sensitivity | YES | NO |
| Kidney or Liver disease | YES | NO | Sinus trouble | YES | NO |
| Neurological disorders | YES | NO | Ulcers (stomach or mouth) | YES | NO |
| Diabetes | YES | NO | Cold sores (fever blisters) | YES | NO |
| Thyroid disease | YES | NO | Snoring/Sleep apnoea | YES | NO |

Have you or are you taking any Bisphosphinates?
e.g Didronel, Bonefos, Fosamax, Alendro, Actonel, Skelid, Aredia Zometa YES NO

Do you have or have you had any disease, condition or problem not listed? YES NO

If yes please list __________

Are you pregnant? YES NO If yes ____ months Nursing YES NO

Are you taking birth control pills? (may affect blood pressure, blood clotting and interact with antibiotics) YES NO

Have you taken any medication or drugs during the past two years? YES NO

If yes please list name and dosage __________

Are you aware of having any allergic or adverse reaction to any medications or substances? YES NO

If yes please list __________

Have you been a patient in hospital in the last 5 years? YES NO

Have you or are you planning to have any Botox or dermal fillers? YES NO

If yes please note details __________

### Have you experienced?

| | | |
|---|---|---|
| Jaw clicking | YES | NO |
| Clenching or grinding | YES | NO |
| Sensitivity to sweet or hot food | YES | NO |
| Pain on biting hard foods | YES | NO |

### Have you ever had?

| | | |
|---|---|---|
| Orthodontic treatment | YES | NO |
| A night guard or splint | YES | NO |
| A poor-fitting denture | YES | NO |

### Do you?

| | | |
|---|---|---|
| Bite your lips or cheeks often | YES | NO |
| Smoke | YES | NO |
| If yes now many per day | ____ | |

### Have you had gum problems? YES NO

| | | |
|---|---|---|
| Do your gums bleed or hurt | YES | NO |
| Does floss tear between your teeth | YES | NO |
| Do you have occasional bad breath | YES | NO |

| | | |
|---|---|---|
| Are you happy with the appearance of your teeth? | YES | NO |
| Are you considering whitening your teeth? | YES | NO |
| Do you expect to keep your teeth your whole life? | YES | NO |
| Have you had an upsetting dental experience, or do you suffer from dental anxiety? | YES | NO |

If yes please describe __________

Is there anything else about having dental treatment that you would like us to know? YES NO

If yes please describe __________

Signature __________ Date __________

## DENTAL INSURANCE

- As a courtesy we are happy to process your health insurance claims on the day of service via our Hicaps facility.
- Item numbers on our statement represent any procedures performed as accurately as possible.
- The conditions of patients' individual health insurance policies determine their eligibility and rates of refund. We accept no responsibility to either party for any decision the insurer may make regarding the refund of monies to the patient.
- Health insurance claims can only be claimed on the day of service for the patient for whom they were performed. For claims to be processed we require your health insurance card. Membership numbers cannot be manually entered into the system. You will be provided with a complete itemised statement for claiming through your health insurance fund should any claims not be processed on the day of service.
- All charges not paid by your health insurance are your responsibility regardless of the reason for non-payment. Not all services we provide are covered by health insurance and benefits differ from one company to another.
- Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods etc is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay.

## PAYMENT POLICY

- Accounts are to be paid in full on the day of service.
- We accept cash, personal cheques, Eftpos cards, Visa, MasterCard and Amex.
  (please note that payments made by American Express will attract a 2% surcharge)

MINOR PATIENTS: The parent or guardian accompanying the child is responsible for full payment. We will not attempt to collect payment from anyone other than the parent accompanying the child at their appointment.

MEDICARE TEEN DENTAL SCHEME: Accounts are to be paid in full on the day of service. Please ensure you have your Medicare card handy so we can process your claim on the day of service. Accounts cannot be supplemented with private health insurance.

RETURNED CHECKS: A $40 charge will apply to your account when a cheque is returned by the bank.

We understand that temporary financial problems may affect the timely payment of your balance. In those circumstances we strongly encourage you to communicate any such problems immediately so that we can assist you in the management of your account. We are happy to discuss payment plan options with you if needed. Should an agreed payment plan not be adhered to, our normal collection procedure will be put in place.

OVERDUE BALANCES AND COLLECTION FEES: All accounts not paid within 90 days will incur a 5% late fee. Should we engage the services of a debt collection agency you agree to pay all debt collection costs and reasonable attorney fees incurred in attempting to collect on your overdue amount.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with **less than 48 hours notice** are considered broken. A charge of $30 per half hour will be made against your account. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept. Broken appointments prevent others from receiving dental treatment. We take all appointments seriously and ask that you please be considerate and inform us in advance if you need to change your appointment.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of **bc dental**. If you need access to your records we will be more than happy to provide copies with written signed consent.

CONSENT AND AUTHORIZATION: I authorise dental treatment and agree to pay all related professional fees. I have read and understood this document in its entirety, outlining the practice and financial policies of **bc dental**.

I agree to abide by the policies outlined herein.

First name ______________________ Last Name ______________________

Relationship to patient if under 18 ______________________

Signature ______________________ Date ______________________