Phillippe O Zimet
REGISTERED SPECIALIST ENDODONTISTS
"Saving Your Natural Teeth"

77 Stud Road Dandenong VIC 3175
PH: 9794 9677
www.zimendo.com

CONFIDENTIAL PATIENT HISTORY

In order to provide the highest standard of care it is requested that you fill in this form carefully and thoroughly.

I will complete this Questionaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I also understand notes or radiographs (x-rays) relating to my treatment may need to be sent to other practitioners to aid them in my treatment, and give my permission for this to occur when necessary.

MR/MRS/MS/DR/PROF ..../................/..................
MASTER / MISS/ THEM/THEY **SURNAME** **DATE OF BIRTH**

GIVEN NAMES (IN FULL) ....

RESIDENTIAL ADDRESS..**PHONE NO:**...

....**POSTCODE**.................**MOBILEPHONE:**..

WHO IS RESPONSIBLE FOR PAYMENT OF YOUR TREATMENT? ....

WHERE DO YOU WORK? ....

WHAT IS THE ADDRESS? ....

.... **POSTCODE** .... **PHONE NO:**..

WHO IS YOUR MEDICAL DOCTOR? .... **PHONE NO:**...

WHO IS YOUR GENERAL DENTIST? .... **PHONE NO:**...

DO YOU HAVE PRIVATE HEALTH INSURANCE – DENTAL COVER ? YES / NO COMPANY:...

PREFERRED CONTACT (please circle) Home phone call Work phone call Mobile phone call SMS reminder

EMERGENCY CONTACT NAME ....**MOB**...

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

Rheumatic fever	YES / NO	Heart Ailments	YES / NO
Diabetes	YES / NO	Hepatitis	YES / NO
Epilepsy	YES / NO	High Blood Pressure	YES / NO
Kidney Disease	YES / NO	Allergic Reaction to Drugs	YES / NO
Asthma	YES / NO	Allergic Reaction to Latex	YES / NO
Excessive Bleeding	YES / NO	Prosthetic implant (hip, heart valve, other)	YES / NO
Are you a smoker?	YES / NO	COVID-19 vaccination – 1 2 3 4	YES / NO

Please give details of any of the above..

....

HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESS? **YES / NO**

Please give details ....

ARE YOU CURRENTLY RECEIVING MEDICAL ATTENTION **YES / NO**

Please give details ....

ARE YOU CURRENTLY TAKING ANY MEDICINES, TABLETS OR RECEIVING INJECTIONS? **YES / NO**

Please give details ....

LADIES: ARE YOU, OR COULD YOU POSSIBLY BE, PREGNANT? **YES / NO**

SIGNED ....**DATE**........./........../.............

Thank you very much for taking the time to complete ***BOTH SIDES OF THIS FORM*** *as fully as possible*.

OFFICE USE: ENDODONTIST CHECK: ....DATE.........../.........../.............

A/Prof. Phillippe O Zimet
BDSc (Melb), LDS (Vic),
MS, Cert Endo (Maryland),
FRACDS, FADI, FICD
ABN 43 597 217 614

Dr James Brichko
BDSc (Hons)
DClinDent (Endo)
MRACDS (Endo)

YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY

In accordance with the Victorian Health Records Act 2001 and Privacy Act

Our practice respects your right to privacy. We realize 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 might be disclosed.

The policy of our practice is to follow these procedures:

I. 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 to you, as well as 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 in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

3. Your health insurance company may request information from your records which we are required to provide. Generally you will have already agreed to allowing your health service provider to release information to the insurance company.

4. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent.

5. 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 an explanation of our records or a written summary, our usual fees apply to these services.

6. If any of the information we have about you is inaccurate or out of date, please ask us to amend our records accordingly.

7. In order to have a report back to your general dentist in a timely manner, we may be sending correspondence via email.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice. Otherwise, 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.

Signed:……………………………………………………………….Date:…… ……/……………../…………

PLEASE PRINT NAME:………………………………………………………………………………………

PATIENT / PARENT / GUARDIAN

Dependent (Patient Name):……………………………………………………………………………

Derived from ADAVB Inc. 2002

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