CONFIDENTIAL – PATIENT DETAILS FORM (UNDER 18)

ALL FORMS MUST BE COMPLETED AND RETURNED TO ADMIN@TSVORTHO.COM.AU PRIOR TO APPOINTMENT DATE

Townsville Orthodontic Specialists

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ Prefers to be called: _____

Patient's Address: _____

Suburb: _____ State: _____ Post Code: _____

Home phone: ( ) _____ Mobile: _____

Name of School that Patient attends: _____

Other family members treated here: _____

Custodial Parent(s) or Guardian(s): _____

Is there a court order in place to indicate who is responsible for Health related decisions? _____

How did you find out about our practice? Family ☐ Friends ☐ Dentist ☐ Yellow Pages ☐ Internet ☐ Other ☐

Your concerns: Crowding ☐ Spacing ☐ Missing Teeth ☐ Finger/Thumb Sucking ☐ Other ☐

Name of Patient's Dentist: _____ Phone No.: _____

Name of Patient's General Practitioner: _____ Phone No.: _____

MOTHERS INFORMATION:

Last Name: _____ First Name: _____Middle Name: _____

Address: _____ Suburb: _____

Postal Address: _____

State: _____ Post Code: _____ Phone No.: ( ) _____Work No: _____

Mobile: _____ Email: _____

Mother's Marital Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____ Other: _____

Employer: _____ Occupation: _____No. Years Employed: _____

Consent to treatment (signature): _____

FATHER'S INFORMATION:

Last Name: _____ First Name: _____Middle Name: _____

Address: _____ Suburb: _____

Postal Address: _____

State: _____ Post Code: _____ Phone No.: ( ) _____Work No: _____

Mobile: _____ Email: _____

Father's Marital Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____ Other: _____

Employer: _____ Occupation: _____No. Years Employed: _____

Consent to treatment (signature): _____

Confirmation of Appointment: SMS Mobile Number…… EMAIL……..

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth for Responsible Party: _____

Address: _____

Suburb: _____ State: _____ Post Code: _____

Years at this address: _____

Postal Address: _____

If less than three years, previous address: _____ Suburb: _____

State: _____ Post Code: _____ Phone No.: _____

Email Address for Accounts and Receipts: _____

Employer: _____ How many years employed: _____

Health Fund for Orthodontic Treatment? YES ☐ NO ☐ Health Fund Name: _____

PLEASE ENSURE THAT ALL DETAILS HAVE BEEN COMPLETED FULLY

It is our intention to be as flexible and liberal as possible with respect to financial arrangements. Accordingly, it is Practice policy to obtain credit reports on our patients. I have read the extracts from the Privacy Act.

Signed: _____ Date Signed: _____

_____
(Name of Responsible Party)

Office Use Only:

FOR DIVORCED/SEPERATED PARENTS

STATEMENT OF AUTHORITY TO RELEASE TREATMENT AND FINANCIAL DETAILS TO THE NON-RESPONSIBLE PARTY

This is to certify that I, _____, as the responsible party for

_____

Hereby authorise Townsville Orthodontic Specialists to release the treatment and financial details to the non-responsible party _____(name and relationship to patient).

Signature: _____Date Signed: _____

Comments:

_____

_____

_____

If you would like a split financial account, then please contact our office so another copy of the forms can be sent. All forms must be returned, completed before the consultation appointment date.

EXTRACTS FROM THE PRIVACY ACT

1. Giving information to a Credit Reporting Agency (Section 18E(8)(c), Privacy Act 1988)

   Townsville Orthodontic Specialists has informed me that it may give certain personal information about me to a credit reporting agency.

2. Access to Commercial Credit Information (Section 18L(4), Privacy Act 1988)

   I/we agree that Townsville Orthodontic Specialists may obtain information about me/us from a business which provides information about the commercial credit worthiness of persons for the purpose of assessing my/our application for consumer credit.

3. Access to Consumer Credit Information (Section 18K(1)(b), Privacy Act 1988)

   I/we agree that Townsville Orthodontic Specialists may obtain a consumer credit report containing information about me/us from a credit reporting agency for the purpose of assessing my/our application for commercial credit.

4. Exchange of Credit Worthiness Information (Section 18N, Privacy Act 1988)

   I/we agree that Townsville Orthodontic Specialists may exchange information with those credit providers named in this application or named in a consumer credit report issued by a credit reporting agency for the following purposes;

   • to assess an application by me/us for credit.

   • to notify other credit providers of a default by me/us.

   • to exchange information with other credit providers as to the status of this loan where I am in default with other credit providers.

   • to assess my/our credit worthiness.

   I/we understand that the information exchanged can include anything about my/our credit worthiness, credit standing, credit history or credit capacity that credit providers are allowed to exchange under the Privacy Act.

5. Agreement to a credit provider being given a consumer credit report by a credit reporting agency to assess a guarantor (Section 18K 1(c), Privacy Act 1988).

   I/we agree that Townsville Orthodontic Specialists may obtain from a credit reporting agency a consumer credit report containing information about me/us for the purpose of assessing whether to accept me/us as a guarantor for credit applied for by, or provided to, the borrower(s) [named in agreement]. I/we agree that this agreement commences from the date of this agreement and continues until the credit covered by the borrower(s) application ceases.

6. Agreement to a credit provider disclosing a report including a consumer credit report to potential or existing guarantor (Section 18K (1), Privacy Act 1988).

   I/we agree that Townsville Orthodontic Specialists may give to a person who is currently a guarantor, or whom I/we indicated is considering becoming a guarantor, a credit report containing information about me/us for the purpose of [name of prospective guarantor] deciding whether to act as a guarantor, or to keep [name of existing guarantor] informed about the guarantee. I/we understand that this information disclosed can include anything about my/our credit worthiness, credit standing, credit history or credit capacity that credit providers are allowed to disclose under the Privacy Act, and includes a credit report.

I have read and understand the above questions and extract from the privacy act. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this Patient Detail Form, I will so inform the practice. It is our intention to be as flexible and liberal as possible with respect to financial arrangements. Accordingly, it is Practice Policy to obtain credit reports on our patients.