Title:_____ Surname:_____ First Name:_____

Address:_____ Suburb:_____

Postcode:_____ Occupation:_____

Date of Birth:_____ Work Number:_____

Home Number:_____ Mobile Number:_____

Email Address:_____

Emergency Contact:_____ Phone:_____

Medicare

No:__ __ __ __ __ __ __ __ __ __

ID: 00 | 01 | 02 | 03 | 04 | 05

Expiry:_____

Dental Health Fund

Fund Name:_____

ID: 00 | 01 | 02 | 03 | 04 | 05

No:_____

Eligible for the Child Dental Benefits Schedule (CDBS) Yes / No (Please circle)

How did you hear about us or who should we thank? (Please specify)

Internet (eg. Facebook, Google)_____ Referral (Patient's Name) _____

Advertisement (eg. Invisalign)_____ Other _____

Do you feel nervous about dental treatment? Yes / No (Please circle)

Date of last dental treatment?_____

Are you currently undergoing any medical treatment or taking any medication? Yes / No (Please circle)

If yes, name of medication and dosage:_____

Physicians name:_____ Phone: _____

Do you have any allergies? eg. Penicillin, Aspirin, Codeine, Erythromycin... Yes / No (Please circle)

If yes, please specify:_____

Please indicate below if any of the following apply to you: (Please circle)

Arthritis/ Rheumatism	Epilepsy	Pregnant
Artificial Joints (hip, knee)	Fainting/ Dizzy spells	Radiation/ Chemotherapy
Asthma	Haemophilia	Sinus troubles
Botox/ Dermal Fillers	Heart conditions	Stomach ulcers
Breastfeeding	Hepatitis	Stroke
Emphysema/ Chronic Cough	HIV/AIDS	Thyroid problems

Other:_____

Are you a smoker? Yes / No (Please circle) If yes, how many per day? _____

Are you interested in the following or in receiving emails on hygiene techniques and special offers?

Whitening Tooth Replacement Teeth Straightening Sleep Disorder

General Anaesthesia/ Sedation General Newsletter Botox/Dermal Fillers

I, the undersigned consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including use of local anaesthetics as indicated and I will assume responsibility for the fees associated with those procedures. **I am aware payment is required on the day of treatment**. **I acknowledge that Child Dental Benefits Schedule (CDBS) eligibility is my responsibility to confirm with Medicare/Services Australia. Any treatment not covered by CDBS will be charged at the practice's standard fees**. In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs. Overdue accounts will be subject to **interest at the rate of 13% pa**, calculated for the period the account is due until the date it is paid. I understand the practice requires **48 hours notice** if I need to cancel or reschedule my appointment, failure to do so might result in a **$50 cancellation fee.** Any unconfirmed appointments might not be kept for their full duration. I understand the practice may contact my next of kin or emergency contact if they are unable to reach me.

Patient/ Parent/ Guardian Signature:_____**Date:**_____

*******PLEASE TURN OVER THE PAGE*******

DO YOU KNOW YOUR RIGHTS?

Signature Smiles Dental understands that everyone has the right to be able to access the highest quality of care. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

My Rights	What this means
Access ***I have a right to health care***	I can access services to address my healthcare needs
Safety ***I have a right to receive safe and high-quality care.***	I receive safe and high-quality health services, provided with professional care, skills and competence.
Respect **I have a right to be shown respect, dignity and consideration**	The care provided shows respect to me and my cultural beliefs, values and personal characteristics.
Communication ***I have a right to be informed about services, treatment, options and costs in a clear and open manner.***	I receive open, timely and appropriate communication about my health care in a way I can understand
Participation ***I have right to be included in decisions and choices about my care.***	I may join in making decisions and choices about my care and about health service planning.
Privacy ***I have a right to privacy and confidentiality of my personal information***	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment ***I have a right to comment on my care and to have my concerns addressed.***	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

Consent to AI-Assisted Clinical Documentation

Our practice may use secure AI-assisted technology to help prepare clinical notes during your appointment. To facilitate this process, a voice recording of the consultation may be made and securely processed to generate a written transcription. The audio recording is used solely for transcription purposes and is deleted once the transcription is complete. The transcription is then used only to assist your dentist in preparing accurate clinical notes.

This technology is used solely to assist with clinical documentation and does not replace professional judgement. Any AI-generated notes are reviewed, edited where necessary, and approved by your treating clinician before being added to your dental record.

Your privacy is important to us. Any information processed through this technology is handled in accordance with applicable privacy laws and our Privacy Policy.

If you would prefer not to have AI-assisted documentation or voice recording used during your appointment, please let our reception team or your clinician know before your consultation, and we will prepare your clinical notes manually.

□ I wish to opt out of AI-assisted documentation and voice recording.

Patient/ Parent/ Guardian Signature:_____ **Date**:_____