Dental Specialist Group Pty Ltd

Dr ELAINE LIM
MDSc (Ortho), BDS (Univ. Medal)
Registered Specialist Orthodontist

creating beautiful smiles
& harmonious bites

Welcome to our specialist orthodontic practice…

Please assist us to provide the best comprehensive care by answering the following questions as thoroughly as possible:

PATIENT DETAILS (as per Medicare Card)

Title:……………Surname:…………………………………………… Given name(s):……………………………………………

Preferred name:…………………………………………… Date of birth:……………………………………

Home address:…………………………………………………………………………Suburb:……………………Postcode:…………

Primary Telephone:……………………………………………… Email:……………………………………………………………

Home:…………………………… Work:………………………………… Mobile:…………………………………

School and year level OR Work Details (if applicable):……………………………………………………………

Relatives/Family members already seen at our practice (names):……………………………………………………

Other Siblings & their ages (if applicable):……………………………………………………………………………

Name of General Dentist and suburb of clinic:
……………………………………………………………
……………………………………………………………

OR

I do not currently have a General Dentist and need a recommendation: ❑

How did you find us?

What was the main reason/motivation for seeing us?……………………………………………………………

Who referred/recommended you to us (a friend/dentist referral/other practitioner)?……………………………………

How else did you hear about us (please tick box)?:

Facebook❑ School❑ Newspaper/Newsletter❑ Website❑ Web Search❑ Dentist/Other Health Care Provider❑ Sign❑
Community/Local Activity Group❑ Instagram❑ Other (please indicate):……………………………………………

PARENT/GUARDIAN (<18 yo) OR NEXT OF KIN (emergency contact / financially responsible party) (>18 yo) DETAILS:

Person responsible for fees (self / father / mother / other):……………………………………………………………

Father (or Parent/Guardian) Title:………. Name:………………………………………………………………………
Address (if different from above):……………………………………………………………………………………
Work:……
Primary Telephone:…………………………………………………… Email:………………………………………………
Home:…………………………………………… Work:……………………………………Mobile:…………………………

Mother (or Parent/Guardian) Title:……….Name: ………………………………………………………………………
Address (if different from above):……………………………………………………………………………………
Work:……
Primary Telephone:…………………………………………………… Email:………………………………………………
Home:…………………………………………… Work:……………………………………Mobile:…………………………

Other Next of Kin/Additional Contact in Case of Emergency Name:…………………………………………………
Relationship to Patient:……………………………………………………………………………………………………
Home Phone:………………………………………… Work Phone:………………………………………Mobile:……………………

Custody (if applicable): ❑ Joint/Shared ❑ Sole parent ❑ Require private discussion with Doctor

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PREVIOUS ORTHODONTIC HISTORY

Consultations:……
Treatment:……
Extraction of teeth:……
Habits (thumb/finger sucking): (Never / Still / Given up (age of cessation))……
Breathing (any sinus / nose / mouth breathing problems) Details:……
Other information you would like to provide regarding dental or orthodontic issues:……
……

ADDITIONAL HEALTH INFORMATION

Name of General Medical Practitioner and suburb of clinic:……
Have you suffered from any of the following? Please circle to indicate YES:
Heart murmur / blood pressure / rheumatic fever / hepatitis / diabetes / asthma / epilepsy / HIV infection / bleeding disorders / other significant medical or congenital/developmental / behavioural condition / pregnant (weeks.....)
Details:……
Have you had an adverse reaction to any treatment or medication (Yes/No):
Details:……
Do you have any allergies (Yes / No) Details:……
Are your immunisations up to date (Yes / No). If No, Details:……
Have you had any injuries or operations, especially in the head or neck area (Yes / No)?
Details:……
Do you take drugs / medicine regularly (Yes (Name) / No)?……
Details (what for):……

PRIVACY POLICY

This practice operates under infection control guidelines established by the National Health and Medical Research Council. All non-disposable instruments and handpieces are sterilised to appropriate standards. Should you have any medical condition which may require further precaution please notify us. If you wish to discuss any medical aspects in private with the doctor please indicate:……

Your health information and our privacy policy in accordance with Victorian Health Records Act 2001 and Privacy Act. Our practice respects your right to privacy. We realise it is important for you to understand the purpose for which we collect details about your health. If is also important that you are informed as to how this information is used at our practice and to whom this information might be disclosed. The practice policy is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information (e.g. name, contact details and health insurance) will be used for the purpose of addressing accounts to you, processing payments and may be forwarded to relevant third parties e.g. debt collection, technical administration/I.T. It may also be used when 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 this is deemed necessary in the context of your treatment. Discussion of your case may be via phone, post or email.
3. We may also use parts of your health information/de-identified photos for research purposes, in study groups, seminars or our social media pages, where the information may be of benefit to other patients or health professionals. Disclosure of your personal details will be minimised wherever possible.
4. Your medical history, treatment records, x-rays and other material relevant to your treatment will be kept at our clinic. You may inspect or request these or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. Should you request an explanation of our records or a written summary, our usual fees will apply to these services.
5. If any of the information we have about you is inaccurate, you must ask us to alter our records accordingly. You can be reassured 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, unless with your consent. If you have any questions or concerns about our handling of your health information, please do not hesitate to raise these with our practice.

Please sign this form as a confirmation of your personal details, your health information and that you have read and understood our privacy policy, and consent to the use of your details in this way.

Signature of (Patient / Parent / Guardian):…… Date:……

Please pass this form back to reception staff once completed. Thank-you.

Professor YOLAND LIM* JP FAICD
Dr JUSTIN LIM MB BCh BAO, FAMAC
Dr SELINA LIM MBBS, FRACGP

ORMOND
328 Jasper Rd
Ormond
VIC, Australia 3204

KNOX
Professor Yoland Lim Building
309 Stud Rd, Wantirna South
VIC, Australia 3152

Phone (03) 9576 9000
Email office@elainelimorthodontist.com.au
Website www.elainelimorthodontist.com.au