PATIENT DETAILS FORM

Charles Sturt University

DENTAL & ORAL HEALTH CLINIC

Patient Details

Family Name: …….. Title: ……..

First Name: …… Middle Name(s): ……..……

Medicare Card No. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ No. of person on card: ____

Date of Birth: ____ / ____ / ____ Gender (circle): Male Female

Address: ……..……

……

Suburb / Town: …… Postcode: ……

Mailing Address (if different from above):

……..……

Suburb / Town: …… Postcode: ……

Contact Details

Mobile Phone: …… Work Phone: ……..…...

Home Phone:……...

Email address: ……..……..

Preferred method of contact: ❑ Mobile Phone ❑ Work Phone ❑ Home Phone ❑ Email

Confirmation of appointments may be sent by SMS.

Do you consent to CSU contacting you by SMS to confirm your appointments? (circle) YES NO

Emergency Contact

Name: ……

Relationship to Patient: …… Contact Phone No.: ……

Concession Cards / Health Insurance

❑ CSU Staff ❑ CSU Student No. ……...

❑ DVA Card ……..… ❑ Pensioner Concession Card ❑ Health Care Card
(Colour of Card)

Card No. …….. Expiry Date (if applicable): ____ / ____ / ____

❑ Private Health Fund ……..
(Name of Fund)

Medical Practitioner Details

General Medical Practitioner Name: ……

Address: ……...

……

PLEASE TURN OVER

Privacy of Patient Information

- ❑ I have read and understand the CSU Dental & Oral Health Clinic Privacy of Patient Information Factsheet

Use of your Information

The Charles Sturt University Dental & Oral Health Clinic provides teaching to students enrolled in courses within the School of Dentistry and Health Sciences.

As explained in the CSU Dental & Oral Health Clinic Factsheet on Privacy of Patient Information, we may wish to use your information for research or teaching purposes. This may include collaborative studies with other institutions. ***If a patient's details are used for such purposes, it is our policy to avoid the identification of the patient in all circumstances.***

I consent (please tick) to information contained in my / my child's clinical record to be used for internal or published:

- ❑ Research
- ❑ Case Studies
- ❑ Lectures and other teaching formats
- ❑ Professional Meetings and Conferences
- ❑ Publications in scientific and professional journals and textbooks
- ❑ Clinical Audits

Signature of Patient / Parent / Guardian ……..

If you are signing on behalf of the patient, please indicate your relationship to the patient:

……..

Date: ____ / ____ / ____