PATIENT DETAILS FORM

Charles Sturt University

DENTAL & ORAL HEALTH CLINIC

Patient Details

Family Name: ..... Title: .....

First Name: ..... Middle Name(s): .....

Medicare Card No. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Position # on card: ____

If your child is under the age of 18 years are they eligible for the Child Dental Benefit Scheme ❑YES ❑NO

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

Address: .....

.....

Suburb / Town: ..... Postcode: .....

Mailing Address (if different from above):

.....

Suburb / Town: ..... Postcode: .....

Contact Details

Home Phone: .....Work Phone: .....

Mobile Phone:.....

Email address: .....

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

Emergency Contact

Name: .....

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

Concession Cards / Health Insurance

❑ CSU Staff ❑ CSU Student No. .....

❑ DVA Card (Colour of Card).....

❑ Concession Card No.....Expiry Date (if applicable): ___/ __ / ___

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

Medical Practitioner Details

General Medical Practitioner Name: .....

Address: .....

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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:

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Date: ____ / ____ / ____