

CONFIDENTIAL

DATE: _____

PATIENT DETAILS FORM FOR ADULT PATIENTS

**ALL FORMS MUST BE COMPLETED AND RETURNED PRIOR TO THE CONSULTATION
APPOINTMENT 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: _____

Postal Address: _____

Home phone: () _____ Mobile: _____ Work phone: () _____

Emergency Contact: Name: _____ Phone: _____

Other family members treated here: _____

Patient is: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employer: _____ Occupation: _____ No. Years Employed: _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our practice? ☐ Yellow Pages ☐ Website ☐ Friends ☐ Family ☐ Other _____

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

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

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

SPOUSE/PARTNER INFORMATION:

Last Name: _____ First Name: _____ Relationship to you: _____

Address: _____ Suburb: _____

Postal Address: _____

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

Work No: _____ Mobile: _____ Email: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Who is financially responsible for this account?

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

Date of Birth for Responsible Party: _____

Address: _____ Suburb: _____

Postal Address: _____

State: _____ Post Code: _____ No.Years at this address: _____

If less than three years, previous address: _____

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

Employer: _____ How many years employed: _____

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

PLEASE ENSURE THAT ALL DETAILS HAVE BEEN COMPLETED FULLY

By signing this document you hereby acknowledge that you have read and understood the Credit Reporting Policy and agree with the contents thereof. Further you consent to the use of your credit information for the purpose outlined. It is our intention to be as flexible as possible with respect to financial arrangements; accordingly it is Practice Policy to obtain credit reports on our responsible financial parties.

Signed: _____ Date Signed: _____
(Responsible Party)

Office Use:



Credit Reporting Policy

1. Townsville Orthodontic Specialists will access and obtain personal credit information about you from a credit reporting business for the purposes of assessing your application for consumer credit.
2. Townsville Orthodontic Specialists will collect the following credit information and credit eligibility information:
 - Name
 - Date of Birth
 - Current / and or previous address
 - Credit related information
 - Historical and current credit related information
 - A report of your credit history from a Credit Reporting Body
 - Information from a Credit Reporting Business which provides information about the credit worthiness of persons

And will hold that information for a period of seven (7) years

3. Townsville Orthodontic Specialists will collect and hold the personal information for the purposes of assessing your application for credit for the cost of orthodontic work and associated procedures.
4. You may access your credit eligibility information held by Townsville Orthodontic Specialists using the below contact details:

Attn: Accounts Manager
Townsville Orthodontic Specialists
17 Martinez Avenue
WEST END, QLD 4810
Phone: 4775 4433 Fax: 4779 8944
5. If you believe that your personal information has been used for purposes other than those which you have authorised, or in accordance with the *Privacy Act 1988*, you may submit a written complaint to Townsville Orthodontic Specialists as soon as possible after you become aware that the disclosure has occurred. Townsville Orthodontic Specialists will send an acknowledgement of the complaint within seven (7) days of its receipt. Townsville Orthodontic Specialists will process the complaint and will provide a written outcome of its investigations within thirty (30) days.

If you are not satisfied with the written outcome provided by Townsville Orthodontic Specialists you may contact the Commonwealth Privacy Commissioner on the Privacy Enquires Lines 1300 363 992.
6. Townsville Orthodontic Specialists may disclose your credit information to a credit reporting body in accordance with a permitted disclosure requirement contained in section 21D of the *Privacy Act 1988*. The credit information that Townsville Orthodontic Specialists may provide to the credit reporting body may include:
 - a. Information relating to consumer credit and commercial credit applied for in Australia.
 - b. Information relating to your repayment history with Townsville Orthodontic Specialists and other credit providers
 - c. Information about any default you have made in your repayments to Townsville Orthodontic Specialists fourteen (14) days after notice of the default has been given to you from Townsville Orthodontic Specialists.
7. Townsville Orthodontic Specialists may provide details of the default to a credit reporting body which could have a negative impact on your future applications for commercial or consumer credit if you default under the terms of your consumer credit contract.

In the event of any inconsistency between this Credit Reporting Policy and the *Privacy Act 1988*, and/or related acts and regulations, this Credit Reporting Policy shall be interpreted so as that the *Privacy Act 1988* will prevail.

OFFICE USE ONLY: (FOR UPDATES)

PATIENT INFORMATION UPDATE OR CHANGES

Comments: _____ Date Signed: _____
(Responsible Party)
Signed: _____ Date Signed: _____
(Staff Member)

PATIENT INFORMATION UPDATE OR CHANGES

Comments: _____ Date Signed: _____
(Responsible Party)
Signed: _____ Date Signed: _____
(Staff Member)

PATIENT INFORMATION UPDATE OR CHANGES

Comments: _____ Date Signed: _____
(Responsible Party)
Signed: _____ Date Signed: _____
(Staff Member)

