Townsville Orthodontic Specialists
For the Smile of Your Life

CONFIDENTIAL **DATE:** _____

PATIENT DETAILS FORM FOR PATIENTS UNDER 18 YEARS OF AGE

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: _____

Home phone: ( ) _____ Mobile: _____

Name of School that Patient attends: _____

Other family members treated here: _____

Custodial Parent(s) or Guardian(s): _____

Is there a court order in place to indicate who is responsible for Health related decisions? _____

How did you find out about our practice? Family ☐ Friends ☐ Dentist ☐ Yellow Pages ☐ Internet ☐ Other ☐

Your concerns: Crowding ☐ Spacing ☐ Missing Teeth ☐ Finger/Thumb Sucking ☐ Other ☐

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

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

MOTHERS INFORMATION:

Last Name: _____ First Name: _____Middle Name: _____

Address: _____ Suburb: _____

Postal Address: _____

State: _____ Post Code: _____ Phone No.: ( ) _____Work No: _____

Mobile: _____ Email: _____

Mother's Marital Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____ Other: _____

Employer: _____ Occupation: _____No. Years Employed: _____

Consent to treatment (signature): _____

FATHER'S INFORMATION:

Last Name: _____ First Name: _____Middle Name: _____

Address: _____ Suburb: _____

Postal Address: _____

State: _____ Post Code: _____ Phone No.: ( ) _____Work No: _____

Mobile: _____ Email: _____

Father's Marital Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____ Other: _____

Employer: _____ Occupation: _____No. Years Employed: _____

Consent to treatment (signature): _____

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

Who is financially responsible for this account?

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

Date of Birth for Responsible Party: _____

Address: _____

Suburb: _____ State: _____ Post Code: _____

Years at this address: _____

Postal 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 Only:

FOR DIVORCED/SEPARATED PARENTS:

STATEMENT OF AUTHORITY TO RELEASE TREATMENT AND FINANCIAL DETAILS TO THE NON-RESPONSIBLE PARTY

This is to certify that I, _____, as the responsible party for

_____

Hereby authorise Townsville Orthodontic Specialists to release the treatment and financial details to the non-responsible party _____ (name and relationship to patient).

Signature: _____ Date Signed: _____

COMMENTS:

_____

_____

_____

If you would like a split account, then please contact our office so another form can be sent. All forms must be returned, completed before the consultation appointment date.

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 with in 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**:** _____

_____

(Parent or Guardian)

Signed: _____ Date Signed: _____

_____

(Staff Member)

PATIENT INFORMATION UPDATE OR CHANGES

Comments: _____ Date Signed**:** _____

_____

(Parent or Guardian)

Signed: _____ Date Signed: _____

_____

(Staff Member)

PATIENT INFORMATION UPDATE OR CHANGES

Comments: _____ Date Signed**:** _____

_____

(Parent or Guardian)

Signed: _____ Date Signed: _____

_____

(Staff Member)