Townsville Orthodontic Specialists
For the Smile of Your Life

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? ____

Name of **Patient's Dentist**: ________________________________ Phone No.: _________________________

Dentist's Address: ____

City: ______________________________________ State: _____________ Post Code: _________________

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

General Practitioner's Address: ____

City: ______________________________________ State: _____________ Post Code: _________________

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: ______________

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

It is our intention to be as flexible and liberal as possible with respect to financial arrangements. Accordingly, it is Practice policy to obtain credit reports on our patients. I have read the extracts from the Privacy Act.

Signed: ____ Date Signed: ____
(Responsible Party)

Date of Birth for Responsible Party: ________________________________

Office Use:

Rating: ☐

EXTRACTS FROM THE PRIVACY ACT

1. Giving information to a Credit Reporting Agency (Section 18E(8)(c), Privacy Act 1988)

   Townsville Orthodontic Specialists has informed me that it may give certain personal information about me to a credit reporting agency.

2. Access to Commercial Credit Information (Section 18L(4), Privacy Act 1988)

   I/we agree that Townsville Orthodontic Specialists may obtain information about me/us from a business which provides information about the commercial credit worthiness of persons for the purpose of assessing my/our application for consumer credit.

3. Access to Consumer Credit Information (Section 18K(1)(b), Privacy Act 1988)

   I/we agree that Townsville Orthodontic Specialists may obtain a consumer credit report containing information about me/us from a credit reporting agency for the purpose of assessing my/our application for commercial credit.

4. Exchange of Credit Worthiness Information (Section 18N, Privacy Act 1988)

   I/we agree that Townsville Orthodontic Specialists may exchange information with those credit providers named in this application or named in a consumer credit report issued by a credit reporting agency for the following purposes;

   - to assess an application by me/us for credit.
   - to notify other credit providers of a default by me/us.
   - to exchange information with other credit providers as to the status of this loan where I am in default with other credit providers.
   - to assess my/our credit worthiness.

   I/we understand that the information exchanged can include anything about my/our credit worthiness, credit standing, credit history or credit capacity that credit providers are allowed to exchange under the Privacy Act.

5. Agreement to a credit provider being given a consumer credit report by a credit reporting agency to assess a guarantor (Section 18K 1(c), Privacy Act 1988).

   I/we agree that Townsville Orthodontic Specialists may obtain from a credit reporting agency a consumer credit report containing information about me/us for the purpose of assessing whether to accept me/us as a guarantor for credit applied for by, or provided to, the borrower(s) [named in agreement]. I/we agree that this agreement commences from the date of this agreement and continues until the credit covered by the borrower(s) application ceases.

6. Agreement to a credit provider disclosing a report including a consumer credit report to potential or existing guarantor (Section 18K (1), Privacy Act 1988).

   I/we agree that Townsville Orthodontic Specialists may give to a person who is currently a guarantor, or whom I/we indicated is considering becoming a guarantor, a credit report containing information about me/us for the purpose of [name of prospective guarantor] deciding whether to act as a guarantor, or to keep [name of existing guarantor] informed about the guarantee. I/we understand that this information disclosed can include anything about my/our credit worthiness, credit standing, credit history or credit capacity that credit providers are allowed to disclose under the Privacy Act, and includes a credit report.

I have read and understand the above questions and extract from the privacy act. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this Patient Detail Form, I will so inform the practice. It is our intention to be as flexible and liberal as possible with respect to financial arrangements. Accordingly, it is Practice Policy to obtain credit reports on our patients.

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

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(Responsible Party)
Signed: ____ Date Signed: ____________________________
(Staff Member)

PATIENT INFORMATION UPDATE OR CHANGES

Comments: ____ Date Signed**:** ____________________________
(Responsible Party)
Signed: ____ Date Signed: ____________________________
(Staff Member)