SPECIAL NEEDS DENTAL TEAM

SND Specialists	Provider no.	Dentists	Provider no.
(1/12) Dr Kerrie Punshon	055216EY	(13) Dr Catherine Fu	4756955A
(3) Dr Warren Shnider	053069DK	(24) Dr Agam Kaur	5860171F
(14) Dr Hajer Derbi	4867926F	**Oral Health Therapist**	
(15) Dr Nikki Liew	297729AA	(12) Ms Natalie Martyn	

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Specialists in Special Needs Dentistry

REGISTRATION FORM

Mr/Mrs/Miss/Ms/Dr Surname (patient): ……..…….....
First Name: ……..…..... Date of Birth:.....
Address: ……..
Post code:.....Daytime telephone number……..….....
Other Contacts (mobile, email, fax etc.): ……..……..….....
Medicare Number: ……..…DVA/Pension/Health Care Card number:.....
Are you eligible for any Dental Benefits? *(Please select)* Select

(Please note our practice is not a preferred provider for any Health Insurance fund and does not bulk bill therefore there will be out of pocket expenses). Also we do not participate in the Child Dental Benefits Scheme.
Do you have: Select below
Who referred you to our practice? .....
Are you currently having any problems with your teeth? Select
If yes: please state what the problem is:…….....……
Do you require HOME VISITS for your dental treatment? Select
If Yes, WHY do you require home visits: ……..……

- Please note: An extra fee to "Travel to provide services" for home visits will apply)

DENTAL/MEDICAL CONSENT– who gives consent

Select _____

(Please note: Paid carers or service providers cannot give consent).
Does the patient have Advanced Care Directive-if yes please provide a copy.
For b and c above:
Print name:……..... Daytime phone:…….……..…
Address:…….....Post code:.....
SIGN:…….....Mobile phone: ……...
Date: .....Relationship: ……..…..……
E-mail: . .....……Work phone: ……...……

FINANCIAL CONSENT – who gives consent *(This person must sign and date the form)*

I agree to pay for any dental accounts generated during an oral examination or subsequent treatment. I understand I will be contacted after the examination, and given a quote for the treatment required.

Print name:…….....Daytime phone:…….……..…
Address:…….....Post code:.....
SIGN:…….....Mobile phone: ……...
Date: .....Relationship: ……..…..……
E-mail: . .....……Work phone: ……...……

(A cancellation fee of $135.00 will apply if we are not informed of the cancellation at least 2 hours prior to the scheduled appointment time. Dishonoured cheques will incur a $30.00 fee. Payment must be made within 21 days of service, if not paid in that time, an additional surcharge of 5% will apply from the date of service) (Accounts referred to a collection agency or solicitor will have all commissions and legal costs added to the account)

- I give consent for the patient (named above) to have a dental examination (which may include cleaning and x-rays) and understand I will be contacted about any additional treatment required.
- I consent to the patient (named above) having clinical photographs taken if required. These photographs may be used for educational purposes in Special Needs Dentistry. No identifying images or information will be provided.
- I give consent for dental/medical records for the patient (named above) to be released to the Special Needs Dental Clinic (named above) and for us to be able to speak to any other health care providers.

PLEASE SIGN & DATE:.....