



NORTHLAND DENTAL GROUP

PATIENT REGISTRATION FORM

PERSONAL DETAILS

Dr Mr Mrs Ms Miss Master

First Name _____ Last Name _____

Address _____

Suburb/Town _____ Postcode _____

Phone _____ Mobile _____

Email _____ Date of Birth _____

Do you have Private Health Insurance? If so, specify _____

Member number # _____ Reference number # _____

Who is responsible for the account? _____

Department of Veterans Affairs Card Number _____

Are there other immediate family members who attended this clinic? If so, specify _____

How would you like to receive a check up reminder via SMS or letter? SMS Letter

EMERGENCY CONTACT DETAILS

Emergency Contact Name _____

Phone _____ Mobile _____

If child, please state Father / Mother / Guardian's name _____

If relevant, Carer name _____ Phone _____

How did you hear about us?

Family member Friend Signage Website Facebook

Instagram Other eg. Google _____

If you were referred here today, whom can we thank? _____

Privacy Policy - We need the information set out above in order to provide you with effective and efficient dental services. You are entitled to access your information at any time and we will keep your information confidential. If necessary, however, we may pass your information on to other health practitioners or debt collection agencies. We may also be required by law to provide your information to outside agencies. Our complete Privacy Policy is available at reception.

Terms of payment - I accept responsibility for my account and understand that the fee is payable on the day. Should I be unable to pay on the day I understand the payment is due within 30 days; if my account exceeds 30 days I understand an account keeping fee may be incurred. If my account remains overdue and is referred to a debt collection agency or solicitors, I may be held liable for the costs of such collection plus interest. I accept full responsibility for health fund claims and rejections. Any fees incurred by the practice for cheques not accepted by the bank may be passed to me.

Signed _____ Date _____