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F.R.A.C.D.S. (OMS) PhD

Oral & Maxillofacial Surgeon

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Oral Surgeon

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CONFIDENTIAL PATIENT INFORMATION

Dr Mr Mrs Miss Ms: Surname ……………….……....Given Name… ……….………

Date of Birth: ……………………..… Age………….. Occupation: …………………..

Residential Address: ………………………………………………Postcode:………

Postal Address: (if different to above)…………………………………………………..

Phone: (H) ………………………. (W) …………………….. (M) ……………………

Email Address:…………………………………………...(for correspondence/ receipts)
I give permission for estimates or invoices to me emailed to the above address: Yes No

Medicare No: __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ / __ __ __ __
Ref No:___ (is the number that appears alongside your name on your card)

Dept Veterans Affairs (DVA) Card No: _ _ _ _ _ _ _ _

Do you have Private Health Insurance: No / Yes

Name of Fund …………...………..…… Membership No: ……………………………

Private Hospital Cover: Yes No Dental Cover: Yes No

Referred by: ....……………………………………………..……………………….

Regular Dentist: ……………………….…………….. Suburb ….. …….……………..…

Regular Doctor: ....…………………………………Suburb..…...…...………………

Person responsible for account: Self / Parent / Name: …..………………………..……
(For Medicare claiming purposes if the parent is responsible for the account could you please provide the following information)
Date of Birth: ……………………… …Phone No: ……………………………………
Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No:___ Expiry Date: _ _ / _ _ _ _

Emergency Contact Details: Name of Contact:………………………………………

Relationship...…………………………………Phone No. ……………………………

PLEASE TURN OVER

MEDICAL HISTORY

Please **circle** the appropriate answer if you suffer from any of the following conditions:

Asthma Chest Complaints Heart Condition

Epilepsy Hepatitis/Jaundice Diabetes: Type I / Type II

Kidney Problems Rheumatic Fever Blood Pressure

Bleeding tendencies Anaemia/ Iron deficiencies Thyroid problems

Any other medical concerns ? ……………………………………………………………

Are you pregnant? No / Yes How many weeks?………………………………..

Are you a smoker? No / Yes How many per day?…………For how long?…….

Have you had any major operations? No / Yes

Please list: ……………………………………………………………..……………………..

Do you have any allergies? No / Yes …………………………………………………

Reaction:……………………………………………………………………………………

Are you taking any **medications**? (please include oral contraceptive pill, asthma preparations, blood thinners, prednisone/steroids, drugs for pain, arthritis, osteoporosis, anti-depressants, vitamins, herbal or Chinese supplements? Yes No

Please List (or provide a copy)……………………..……………………………………
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Collection of Personal Information, HRIP Act 2002 (NSW) and Privacy Act 1988 (Cth)
We acknowledge our obligations under **The Health Records and Information Privacy HRIP Act 2002 (NSW)** and **The Privacy Act 1988 (Cth)**. These Acts regulate the way in which we **collect, hold, use** and **disclose** your information.

We are committed to maintaining your personal health information as your medical record is a confidential document. It is the policy of this practice to maintain confidentiality at all times and maintain the security of your personal health information at all times and to ensure that this information is only available to authorized members of staff or other health professionals as considered necessary in the context of your treatment.

If you would like to read more about our Privacy Policy or the HRIP Act 2002 (NSW) or The Privacy Act 1988 please see the link on our website.

Patient's Signature :______________________________ Date: ______________