

# Patient Registration Form - Melbourne Implant Oral & Maxillofacial Surgery



## PATIENT INFORMATION: Please print in block letters.

Surname: \_\_\_\_\_ Title: \_\_\_\_\_

First & Middle Name(s): \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Postal Address: (if different) \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

### Contact Details:

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Form of Contact: \_\_\_\_\_

Guardian/ Next of kin (if applicable) \_\_\_\_\_ Phone: \_\_\_\_\_

Person responsible for account: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## REFERRAL AND PRACTITIONER DETAILS:

**Referring Practitioner:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**General Medical Practitioner (GP):** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**General Dentist:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## MEDICARE & HEALTH INSURANCE DETAILS:

### Medicare Details:

Card No: \_\_\_\_\_ Ref No (digit next to your name): \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_

### Private Health Insurance:

Fund Name: \_\_\_\_\_ Member No: \_\_\_\_\_

Dental Extras Fund: \_\_\_\_\_ Hospital Cover: \_\_\_\_\_

**Veteran Affairs:** Card No: \_\_\_\_\_ Gold/White (please circle) Expiry Date: \_\_\_\_/\_\_\_\_

**TAC/Workcover:** Insurer: \_\_\_\_\_ Claim No: \_\_\_\_\_

Claims Contact: \_\_\_\_\_ Date of Injury/Accident: \_\_\_\_\_

**PLEASE TURN THE PAGE AND COMPLETE THE MEDICAL SUMMARY SECTION**

**MEDICAL SUMMARY:****HAVE YOU HAD OR CURRENTLY HAVE...**

	YES	NO		YES	NO
Rheumatic fever			Hepatitis		
Diabetes			Asthma		
Heart problems			High blood pressure		
Heart murmur			Osteoporosis		
Epilepsy			Stomach reflux/ulcer		
Kidney disease			Excessive bleeding		

**DO YOU HAVE ALLERGIES TO...**

	YES	NO		YES	NO
Penicillin			Latex		
Aspirin			Elastoplast or tapes		
Any other medication?			Any other allergies?		
Any foods?			List:		
List:					

	YES	NO
Have you smoked cigarettes/cigars within the last 4 weeks?		
Are there any other "risk factors" you need to discuss in your consultation?		
Have you EVER taken any medications or had regular injections for osteoporosis or bone conditions/lesions? (eg. Denosumab, Prolia, Fosamax, Actonel, Zometa, Pamisol, Didronel, Didrocal, or Aredia)		

**Please list ALL medications you are currently taking (including vitamin supplements and inhalers):**


**Please list ALL previous operations:**


**Describe any serious illness you have previously suffered:**


**Females: Are you pregnant?****YES****NO**

Are you taking the oral contraceptive pill?

YES

NO

**Have you had problems with general anaesthetics or a family history of malignant hyperthermia?**

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**PRIVACY STATEMENT**

Our practice respects your right to privacy and complies with the legislation relating to the collection, storage, use and disclosure of health information. For more information please ask for the Privacy Statement handout.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian to sign if the patient is under 18 years)