Patient Registration Form - Melbourne Implant Oral & Maxillofacial Surgery

Surname: _____ Title: _____ Sex (M/F/Other): _____

First & Middle Name(s): _____

Preferred Name: _____ 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: _____

Medicare Card Number (for person responsible for account)

Card Number: _____ Ref#_____ Expiry Date: _____

REFERRAL AND PRACTITIONER DETAILS:

Referring Practitioner: _____

Address: _____ Phone: _____

General Medical Practitioner (GP): _____

Address: _____ Phone: _____

General Dentist: _____

Address: _____ Phone: _____

MEDICARE & HEALTH INSURANCE DETAILS:

Medicare Details (For Patient):

Card No: _____Ref No (digit next to your name): _____ Expiry Date: _____/_____

Private Health Insurance:

Fund Name: _____ Member No: _____

Dental Extras Fund: ☐ Yes ☐ No _____ Hospital Cover: ☐ Yes ☐ No _____

Veteran Affairs: Card No: _____ 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?

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)