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: _____

Patient Contact Details:

Home: _____ Mobile: _____ Work: _____

Email: _____ Preferred Form of Contact:_____

Guardian/ Next of kin (if applicable) _____ Phone:_____

Person responsible for account details (if not self or if patient is under the age of 18 this must be completed as it required by Medicare & Private Health Funds):

Name: _____ DOB:_____

Address: _____ Phone: _____

Medicare Card Number (for person responsible for account, this allows us to submit your Medicare Claim for you for the consultation)

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 _____

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:		

	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:

Have you been Diagnosed with COVID-19	□ Yes □ No	**If Yes, When?:**
What symptoms have you had or, what symptoms may you still have?		
Have you been Vaccinated against COVID-19?		
1st Dose □ Yes □ No Date of Vaccination:	**4th Dose** □ Yes □ No Date of Vaccination:	
2nd Dose □ Yes □ No Date of Vaccination:	**5th Dose** □ Yes □ No Date of Vaccination:	
3rd Dose □ Yes □ No Date of Vaccination:	**6th Dose** □ Yes □ No Date of Vaccination:	

List <u>ALL</u> serious Medical Illnesses & Conditions that you either suffer from or you have previously suffered from:

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?

<u>PRIVACY STATEMENT</u>
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.

Patient Signature _____ **Date** _____
(Must be signed by Patient or Parent/Guardian to sign if the patient is under 18 years)