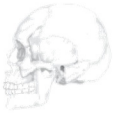

SPECIALIST
ORAL &
MAXILLOFACIAL
SURGERY

PATIENT INFORMATION & CONSENT

Mr/Mrs/Miss/Ms/Other

First Name:_____ **Surname:**_____

Known As/Preferred Name:_____ **Date of Birth:**_____

Address:_____

Mobile:_____ **Home Phone:**_____

Work Phone:_____

Email Address:_____

Medicare Number:_____ **Ref:**_____ **Expiry Date**:_____

Payee Details *(parents/if different to the patient for claiming purposes):*_____

Name:_____ DOB:_____

Medicare Number:_____ Position:_____

Address (if different to the patient):_____

Private Health Fund:_____ **MemberNumber:**_____

Next of Kin Name:_____

Mobile:_____

Relationship to you:_____

Referring Doctor/Dentist:_____

Usual General Practitioner Name:_____

Clinic/Practice Name:_____

Contact:_____

Please Note: Your surgeon is a Medical Practitioner so full disclosure will ensure your best care.
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

How did you find out about our practice: Referring doctor/dentist, Internet search, Word of mouth.

Is there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP? If so, please list them:

Name: _____

Address:_____

Phone:_____

CONSENT TO COLLECT PATIENT INFORMATION:

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Patients Full Name (Please print):_____

Signature:_____Date:_____

WORKERS COMPENSATION/MOTOR VEHICLE INSURANCE/INSURANCE PATIENTS ONLY

Date of accident:_____Claim number:_____

Injury:_____

Employer/Company:_____

Where Injury Occurred:_____Employer Contact:_____

How injury occurred:_____

Employers Insurance Co:_____

PERSONAL HEALTH HISTORY

Are you currently undergoing treatment with GP or specialist? **YES** ☐ **No** ☐

If so, please explain briefly:_____

Name of Dr and practice (if different to GP):_____

Have you recently had the cold or flu? **YES** ☐ **NO** ☐

NOTE: If you have been admitted to any hospital outside WA/Australia within the last 12 months please let our staff know.

PAST SURGICAL PROCEDURES

Procedure	Year	Hospital

NONE ☐

MEDICATION

Medication	Strength	Time Taken

NONE ☐

ALLERGIES

Penicillin	
Pain killers *(e.g. codeine)*	
Latex	
Iodine	
Other *(please list)*	

NONE ☐

Have you ever suffered from *(please tick or cross in appropriate box)*	**YES**	**NO**
Bronchitis, asthma or other chest conditions		
Fainting, giddiness, blackouts or epilepsy		
Heart problems e.g. angine, congenital heart disease/valvular heart disease/rheumatic fever		
Diabetes – Type 1, Type 2 or gestational		
Abnormal blood pressure – Low or High		
Blood disorder/prolonged bleeding/taking blood thinning medication*(e.g. warfarin/asprin)*		
Cancer		
Liver Disease *(e.g. jaundice, Hepatitis)*		
Kidney Disease		
A bad reaction to general or local anaesthetic *(e.g. post-operative nausea)*		

Are you currently *(please tick or cross in appropriate box)*

Receiving treatment from a doctor, hospital or clinic		
Have you had a Lap Band surgery/bariatric surgery		
Having radiation therapy to head or neck		
Receiving chemotherapy		
Have you ever been on IV or Oral bisphosphonate medication *(e.g. prolia, Fosamax – used to prevent loss of bone mass)*		
Taking the contraceptive pill		
Pregnant or possibly pregnant		
Breastfeeding		
Having corticosteroid treatment *(long term)*		

Do you use tobacco? YES/NO **If yes how many per day? _____**
Have you given up?_____

Do you drink alcohol? YES/NO **How many units per day/week?_____**

WEIGHT _____Kgs **HEIGHT_____Cm** **BMI_____**
For anaesthetic purposes, we need to know the weight and height for all patients.

I, the above patient, have been truthful and answered all questions to the best of my knowledge. I consent to the collection and use of the above information, and all further information requested by and given to staff of Clinical A/Professor Dieter Gebauer and/or Dr Leon Smith during this and all subsequent consultations, to help and provide an accurate medical diagnosis and to facilitate treatment, including correspondence to my referring/family doctor.

NAME:_____ SIGNATURE:_____

DATE:_____