NORTHSHORE
Oral and Maxillofacial Surgery

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Oral and Maxillofacial Surgeon
MD, DDS, PHD(Med), PHD(Dent), FGAOMS(Ger)

NEW PATIENT INFORMATION

**Our doctors and staff collect information from patients to provide proper care and treatment.
Patient information may be disclosed to other health care professionals when appropriate.
All information will be handled CONFIDENTIALLY.**

MRS/MS/MISS/MR FAMILY NAME_____FIRST NAME_____

ADDRESS_____SUBURB_____ POST CODE_____

POSTAL ADDRESS_____ SUBURB_____POST CODE_____

HOME PHONE No_____ BUSINESS No_____ MOBILE_____

DATE OF BIRTH_____ SEX: ☐ M ☐ F OCCUPATION _____

MEDICARE No_____REF No (The number next to your first name) :____ Expiry Date _____

VETERANS' AFFAIRS No_____ EMAIL ADDRESS_____

YOUR FAMILY DOCTOR_____ REFERRING DOCTOR/DENTIST_____

DO YOU HAVE PRIVATE HEALTH INSURANCE? ☐ YES ☐ NO
HOSPITAL COVER? ☐ YES ☐ NO **DENTAL COVER?** ☐ YES ☐ NO

NAME OF FUND _____ MEMBERSHIP No _____

NAME OF MEMBER _____

EMERGENCY CONTACT DETAILS:

NAME _____ TELEPHONE No _____ _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____

MEDICAL HISTORY:

Rheumatic fever	Yes	No	Bleeding Disorders	Yes	No	
Angina	Yes	No	Bruise Easily	Yes	No	
Heart conditions/Murmurs	Yes	No	Hip/Joint Surgery	Yes	No	
Nervous Disorders/Epilepsy	Yes	No	Diabetes	Yes	No	
Asthma	Yes	No	Hepatitis A/B/C	Yes	No	
Arthritis	Yes	No	HIV	Yes	No	
Blood Pressure Condition	Yes	No	Smoker	Yes	No:	Quantity:
Reflux/Stomach Ailments	Yes	No	Do you drink alcohol	Yes	No:	Quantity:
			Pregnant	Yes	No	

HAVE YOU OR FAMILY MEMBERS HAD ANY PROBLEMS WITH PREVIOUS ANAESTHETICS? Please List:
_____

OTHER ***MEDICAL CONDITIONS***: Please List _____

ARE YOU CURRENTLY TAKING ***MEDICATION?***:(including: Aspirin, Steroids, Contraceptives, anti-clotting medication)

Please List:_____

PLEASE LIST PREVIOUS MAJOR OPERATIONS: _____

DO YOU SUFFER FROM ANY ***ALLERGIES?*** (ie: MEDICATION, ANTISEPTICS, FOOD, LATEX):

Please List:_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN: _____ DATE:_____

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