Norwest Oral and Maxillofacial Surgery

REGISTRATION FORM

(Please Print)

Referring Doctor/Dentist: | Today's date:

Are you covered by a health fund? ❑ Yes ❑ No | Is this related to a Workers Compensation or Third Party Injury? ❑ Yes ❑ No

PATIENT INFORMATION

Patient's last name:	First:	❑ Mr ❑ Mrs	❑ Miss ❑ Ms	Occupation:

Is this the name shown on your Medicare Card? ❑ Yes ❑ No	If not, what is the name on your Medicare Card?	Home phone no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Mobile phone no.:	Work phone no.:

P.O. box:	Suburb/Town:	Postcode:

Email address:	Centrelink Pension or HCC No: Exp:

Name of Health Fund: Membership Number: ID number next to your name:	Dental Cover: ❑ Yes ❑ No Hospital Cover: ❑ Yes ❑ No	Medicare No: M/C Card Ref: Exp: (Number next to your name on the card)

How did you hear about our practice? (please tick all applicable) ❑ Dr ❑ Close to home/work ❑ Fund ❑ Hospital

❑ Family/Friend * ❑ Internet ❑ Yellow Pages ❑ Other

*Name of friend or family member who recommended this practice (so we can thank them):

INFORMED CONSENTS

I consent to Norwest Oral and Maxillofacial Surgery contacting my referring doctor, GP and other external health care providers involved in my ongoing care for the purpose of obtaining clinical information to assist in my ongoing management.
❑ Yes ❑ No

I consent to Norwest Oral and Maxillofacial Surgery releasing my clinical information to my referring doctor, GP and other external health care providers involved in my ongoing care for the purpose of assisting in my ongoing management.
❑ Yes ❑ No

Occasionally Dr Naim will have dental and medical students observe consultations and procedures with your permission. **The student will NOT perform any surgery or procedures.** I consent to being observed by students for the purpose of teaching and research. ❑ Yes ❑ No

Photography and medical imaging may form part of your medical record. Occasionally Dr Naim may use these photos, with reasonable identity protection, for educational purposes in lectures and online. I consent to the use of these images as outlined ❑ Yes ❑ No

PRIVACY POLICY

Your medical records are confidential.
No results will be given over the telephone.
Results will only be given to third party medical practitioners if the above consents have been obtained.
It is the policy of this practice to maintain security of personal health information at all times and to ensure this information is only available to authorised members of staff.

IN CASE OF EMERGENCY

Name of emergency contact person:	Relationship to patient:	Home phone no.:	Work/Mob phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for all accounts (with the exception of Workers Compensation or Third Party claims).

PATIENT/Guardian signature *Date*

PTO

MEDICAL HISTORY

Please tick if you presently have or had in the past, any of the following conditions:

Rheumatic fever	Asthma	Jaw muscle pain (TMD)
High blood pressure	Tuberculosis	Back/neck pain
Cholesterol	Epilepsy	Osteoporosis
Heart attack/angina	Kidney disease	HIV
Heart murmur	Thyroid disorder	Hepatitis
Heart pacemaker	Liver disease	Sleep apnoea
Heart valve replacement	Diabetes	Excessive bleeding
Stroke	Eating Disorder	Cancer past/present
Recent hospitalisation	Anaemia	Arthritis
Artificial joint	Depression	Other (please specify)

Have you ever been treated by an Orthodontist? ❑ Yes ❑ No If so, who?

Ladies are you, or might you be pregnant? ❑ Yes ❑ No If so, when is the due date?

Do you smoke? ❑ Yes ❑ No Number per day:

Are you being treated by a medical specialist? Please give details:

Name, Address & Phone No of your local dentist:

Name, Address & Phone No of your local doctor:

Are you allergic to any medications, latex or any other substances? Please list:

Are you currently taking any medications? If so please list:

Have you ever or are you currently taking any bisphosphonate medications (for osteoporosis)? (eg Fosamax, Actonel)

❑ Yes ❑ No Name of bisphosphonate medication:

This information represents my medical history to the best of my knowledge. Any changes will be advised at subsequent appointments.

Signed ______________________ Date ______________

Name