Precision Oral Surgery

ORAL & MAXILLOFACIAL SURGEONS
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PATIENT REGISTRATION & MEDICAL HISTORY

Welcome to Precision Oral Surgery, please take some time to complete this form as accurately and completely as possible. If you have any concerns or questions please speak to any of our staff for assistance. Precision Oral Surgery are committed to protecting the privacy of patient information in a responsible manner and in accordance with all privacy legislations.
A copy of our Privacy Policy is available at reception.

Title:________________ First Name: ______________________________ Last Name:_______________________________

Preferred Name: ____ Date of Birth:______________________________

Residential Address:

____

Phone:__________________________________ Email address:____

Occupation:_____________________________ Name of referring dentist/doctor:______________________________________

Emergency Contact:____ Phone: _____________________________________

Private Health Insurance: ☐ YES ☐ NO Private Health Insurance Extras: ☐ YES ☐ NO

Name of Health Fund ________________________________ Membership No. /Ref. __________________________/___________

Medicare No: _______________________________________ Reference No: (No. next to name) _________

For patient under 18 years of age on a family Medicare card please supply details below:

Parent name: __________________________________ Parent DOB: _____________Reference No: (No. next to name) _________

Person responsible for payment of fees:

____
Name Address Phone

Have you ever had any of the following: (if yes please circle)

☐ Heart Problems	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Stroke
☐ Asthma	☐ Chest or Breathing Problems	☐ Diabetes	☐ Kidney Disease
☐ Bleeding Problems	☐ General Anaesthetics	☐ Epilepsy or Fits	☐ Hepatitis A B or C
☐ Anaemia	☐ Complication with Anaesthetics	☐ Stomach or Bowel Problems	☐ Osteoporosis/Bone Disorders

Weight:________________kg Height:_______________cm (required if treatment may be received under general anaesthetic)

Do you take any Medications: ☐ YES ☐ NO (please detail): ____

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____

Are you Allergic to any Drugs, Foods or Substances: ☐ YES ☐ NO (please detail) ________________________________

____

Do you smoke cigarettes ☐ YES ☐ NO ☐ OCCASIONALLY

Do you use recreational Drugs ☐ YES ☐ NO ☐ OCCASIONALLY

If female, are you Pregnant? ☐ YES ☐ NO ☐ POSSIBLY

If you have any further information that may be relevant to your treatment please detail below:

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____

____

Patient / Guardian Signature: ____ DATE: _____/_____/_____