ORAL SURGERY CLINICS

PATIENT REGISTRATION AND MEDICAL HISTORY

Please print in block letters thankyou

PERSONAL DETAILS

Please put details as per Medicare

Title: Dr/Mr/Mrs/Ms/Miss/Mst Date of Birth_____

Surname: _____

First Name: _____

Address: _____

Suburb: _____ Post Code: _____

Occupation:_____

Home Phone: _____

Mobile: _____

Email: _____

(If patient is under 18 please provide guardians email)

To improve efficiency we send correspondence via email

Please tick if you DON'T have access to email

☐ Post

***you will only be sent information regarding your treatment*

ACCOUNT DETAILS

Medicare Number: __ __ __ __ __ __ __ __ __ __ __

Reference number (number next to your name): __

Private Health Insurance: _____

Membership number: _____

Hospital Cover? ☐ Dental Extras Cover? ☐

Person Responsible for Fees

(Write self if you are paying the account)

Name: _____

Address: _____

Relationship to Patient: _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ __

Reference number (number next to your name): __

Date of Birth: _____ Phone Number: _____

MEDICAL HISTORY

This information is confidential

Emergency contact name: _____

Contact number: _____

Relationship to patient: _____

Have you ever suffered from the following?

☐ Angina

☐ Arthritis

☐ Asthma

☐ Bleeding problems

☐ Complications with anesthetics

☐ Diabetes

☐ Epilepsy/fits

☐ Heart Problems

☐ Hepatitis A, B or C

☐ High Blood Pressure

☐ Liver problems

☐ Lung problems

☐ Rheumatic fever

☐ Stroke

☐ Thrombosis

Do you have any Allergies?

_____

Do you have an artificial heart valve or joint replacement?

Y / N details:_____

Any other illnesses Y / N : _____

Please list any medication you are taking (including Ventolin puffers and contraceptive pill)

_____

_____

_____

Do you smoke Y / N How many per day?_____

Do you use recreational drugs Y / N

Details_____

Ladies are you pregnant? Y / N

PLEASE TURN OVER PAGE

ORAL SURGERY
CLINICS

PRIVACY POLICY

Our practice respects you right to privacy. We realise that it is important that you understand the purpose for which your personal and health information is collected, as well as how this information is used and to whom this information might be disclosed.

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing account to you, as well as processing payments and writing to you about issues affecting you treatment.
2. We may disclose your health information to other healthcare professionals and hospitals, or request it from them if it is necessary in the context of your treatment. Disclosure of your personal details will be minimized to relevant information
3. Information may be disclosed to and requested from other people or organizations in order to finalise accounts in a timely manner.
4. Your assistance is requested by providing updated personal and health information at subsequent visits, particularly regarding changes to your health and medications. When additional information is provided we will keep your records up-to-date, accurate and complete.
5. Anonymous details of your health information and treatment may be used for research, study or educational purposes. Your personal identity would not be disclosed without your consent.
6. Your medical history, treatment records, radiographs and any other material relevant to your treatment will be retained in a secure manner. When no longer required, information may be destroyed in accordance with government regulations.
7. We will maintain and abide by a Practice Privacy Policy that conforms to Government regulations. You may request a copy of the current Practice Privacy Policy at any time.
8. You may inspect or request copies of your records at any time or seek an explanation. Statutory fees will apply in relation to the type of access you seek.
9. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly

You can otherwise rest assured that your personal and health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice without your prior written consent. If you have any questions or concerns about our handling of your health information, please do not hesitate to discuss these issues with our practice staff.

Please be aware that if you have an appointment booked with us and you do not arrive or if you cancel with less that 24 hour notice a no show/cancelation fee may apply

Signed_____Date_____

If the patient is under 18 years of age, a parent or guardian must sign and provide a daytime contact number