DR KRISTIAN VAN MOURIK

ORAL & MAXILLOFACIAL SURGEON

NEW PATIENT REGISTRATION FORM

□ Mr □ Mrs □ Ms □ Miss □ Master □ Dr

Surname .... First Name...

Date of Birth ..../............/............

Postal Address ....

Suburb .... Postcode .... Occupation ....

Daytime phone .... Mobile ....

Email address..

Medicare Number .... Ref Number .... Card Expiry ..../................

Pension/DVA .... Card Expiry ..../................

Private Health Insurer .... Card Number ....

Emergency Contact

First Name .... Surname ....

Relationship to Patient .... Mobile Number..

<u>Patients under 18yrs or under Parent Medicare Card</u>

Guardian full name.. Guardian DOB. ..../................./....................

Guardian Medicare number .... Reference number ....Card Expiry: ..../.........

Guardian email address...

I consent to the collection of my personal and health information in accordance with the Australian Privacy Principals. I have properly disclosed my personal details and medical history. I understand the information provided may be used in the following ways.

- Billing and administrative purposes including compliance with Medicare Australia

- Disclosure to other health care professionals, including treating doctors & specialists outside this medical practice. This can occur through referral to other doctors and referral for medical tests.

Patient/Guardian Signature: .... Date ....

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MEDICAL HISTORY

Name of general practioner ………………………………………………………………… Suburb ……………………………………

Name of dentist ………………………………………………………………………………… Suburb ……………………………………

	Yes	No
Have you had any serious illness, operation or hospitalization within the past 5 years? If 'yes' ………………………………………………………………………………………………………		
Have you had an artificial joint replacement (knee, hip, shoulder, etc.)?		
Are you taking or have you ever taken Bisphosphonates or other medicines for osteoporosis (ie. Prolia, Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa) ?		
Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? If 'yes'……… …… ……		
Damaged heart valves, artificial valves, pacemaker or heart murmur?		
Rheumatic heart disease or endocarditis		
Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition If 'yes' ………………………………………………………………………………………………………		
Low or high blood pressure		
Asthma		
Diabetes		
Hepatitis, jaundice or liver disease		
Thyroid problems		
Respiratory problems, emphysema, bronchitis, etc		
Arthritis or painful, swollen joints including jaw joint		
Osteoporosis		
Stomach ulcer or hyperacidity		
Neuromuscular condition (eg Myasthenia Gravis or Lambert-Eaton)		

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	Yes	No
Kidney trouble		
Epilepsy, seizures or neurological disorder		
Have you ever had cancer or treatment for a tumour or growth?		
Have you had radiation therapy to the head, neck or jaws?		
Any disease, drug or transplant operation that has depressed your immune system?		
Have you had abnormal bleeding or required a blood transfusion?		
Do you have any blood disorder such as anaemia or haemophilia?		
Are you allergic to or have you had a reaction to:	Yes	No
Local anaesthetics …………………………………………………………………………………………		
Penicillin or antibiotics………………………………………………………………………………		
Sulphur drugs ……………………………………………………………………………………………		
Barbiturates or sleeping pills ………………………………………………………………………		
Aspirin ……………………………………………………………………………………………………		
Iodine ………………………………………………………………………………………………………		
Codeine or other narcotics …………………………………………………………………………		
Latex or other rubber products ……………………………………………………………………		
Other ………………………………………………………………………………………………………		
Do you smoke? If 'yes' how many/day ………………….		
Do you drink alcohol? If 'yes' roughly how much?		
Use of illicit drugs?		
Anxiety /depression?		
Pregnant / trying to become pregnant / nursing		

I have read and understand the above. I understand it is my responsibility to fill out the form correctly.

Patient/ Guardian signature …………………………………………………………….. Date ………………………………