SSOMS
Sydney South Oral and Maxillo-facial Surgery

**SYDNEY SOUTH ORAL & MAXILLO FACIAL SURGERY**

**Dr Anthony Anker, Dr David Sherring & Dr Tristan Madden**
***Surgery of the Face and Jaws***
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## CONFIDENTIAL PATIENT INFORMATION

Dr Mr Mrs Miss Ms Mstr Surname …….…..…….. Given Name. ……..…….……

Address ……..……Suburb:……Postcode:……...

Phone: (H) ……..…… (W) …… (M) ……..

Date of Birth: ……..… Age……..….. Occupation: ……..…….

Referred by: .....……..……

Regular Dentist: ……..…….. Suburb ….. ……..…….……

Regular Doctor: ...…… Suburb..…..…...……

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No:___ Expiry Date: __ __ / __ __ __ __
**(Medicare Ref No is the number that appears alongside your name on your Medicare card)**

Do you have Private Health Insurance: Yes☐ No☐ Name of fund:……

Health fund number : ……..Private hospital cover Yes☐ No☐ Dental Cover Yes☐ No☐

I give permission for appointment details to me emailed or texted to mobile number shown above Yes☐ No☐

I give permission for estimates and/or invoices to be emailed to the following email address Yes☐ No☐

Email address for estimates and/or invoices……..

**Person responsible for account (Self / Parent's Name)** : ……..……..……..
**(For Medicare claiming purposes if the parent is responsible for the account could you please provide the following information)**

Date of Birth: …… Phone No: …….

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No:___ Expiry Date: __ __ / __ __ __ __

**Emergency Contact Details**: Name of Contact / Relationship..……..……

Phone No. …….. ...……

**Have you or any member of your family attended this surgery before?** Yes☐ No☐

If Yes, name and approximate year ……

**PLEASE TURN OVER**

## MEDICAL HISTORY

Please **tick** the appropriate box if you suffer from any of the following conditions:

| | | | | | |
|---|---|---|---|---|---|
| Asthma | ☐ | Chest Complaints | ☐ | Heart Condition | ☐ |
| Epilepsy | ☐ | Hepatitis/Jaundice | ☐ | Diabetes | ☐ |
| Kidney Problems | ☐ | Rheumatic Fever | ☐ | Blood Pressure | ☐ |

Any others ? ……..……..

Are you pregnant? Yes ☐ No ☐

Are you a smoker? Yes ☐ No ☐

Have you had any operations? Yes☐ No☐

Please list: ……..……..……..……

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Have you been admitted to hospital for any reason? Yes☐ No☐

Please list.……

Do you have any allergies? Yes☐ No☐

Please list:.……

Hepatitis and other viruses are of increasing concern in Health Care. Could you be in the high risk category of viral infection? Yes☐ No☐

Are you taking any **medications**? (include oral contraceptive pill, asthma preparations, blood thinners, drugs for pain, arthritis, osteoporosis, anti-depressants, vitamins, herbal or Chinese supplements? Yes☐ No☐

Please List.……..…..……..……..……..……..

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**Collection of Personal Information, HRIP Act 2002 (NSW) and Privacy Act 1988 (Cth)**

We acknowledge our obligations under **The Health Records and Information Privacy HRIP Act 2002 (NSW)** and **The Privacy Act 1988 (Cth)**. These Acts regulate the way in which we **collect, hold, use** and **disclose** your information.

We are committed to maintaining your personal health information as your medical record is a confidential document. It is the policy of this practice to maintain confidentiality at all times and maintain the security of your personal health information at all times and to ensure that this information is only available to authorized members of staff or other health professionals as considered necessary in the context of your treatment.

***If you would like to read more about our Privacy Policy or the HRIP Act 2002 (NSW) or The Privacy Act 1988 please ask our reception staff.***

Patient's Signature :_____ Date: _____