



Dr Anthony Anker, Dr David Sherring & Dr Tristan Madden

Surgery of the Face and Jaws

Suite 406, Level 4, 533 Kingsway, Miranda, NSW, 2228

Ph: 9526 1133 Fax: 9540 2095

Email: reception@sydneyouthoms.com.au Website: sydneyouthoms.com.au

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 be 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	<input type="checkbox"/>	Chest Complaints	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	Diabetes (type)	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Blood Pressure	<input type="checkbox"/>

Mental Health / Psychiatric conditions Details/Diagnosis.....

Treating Psychiatrist details

Cancer Type / Location /Treatment.....

Oncologist details

Any other conditions ?

Are you pregnant? Yes No

Are you a smoker? Yes No Number per day?.

Have you had any operations? Yes No

Please list:

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**? (circle) Yes No

Oral contraceptive pill Drugs for pain, arthritis,

Asthma preparations (Ventolin, Seretide) Blood thinners (Warfarin, Pradaxa, Eliquis, Xarelto)

Drugs for osteoporosis injections/tablets (Prolia/Actonel/Fosamax/Zometa) – Date of last dose

Anti-depressants, Vitamins, Herbal or Chinese supplements?

Please List Medications.....

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: _____