SYDNEY ORAL MEDICINE

YOUR DETAILS (Please print clearly)

Title. . . . . .Surname……Given Names……...……..

Preferred name.....

Date of birth……..……..... Gender: □ Male □ Female

Address……..…

Suburb…….....State……Postcode…....…..…

Telephone:.(H)…….(M)……

(B)……Occupation.....

Email……..

NEXT OF KIN/PERSON TO CONTACT IN EMERGENCY

Name:……..Relationship to patient……..

Contact number:.....

PRIVATE HEALTH INSURANCE & MEDICARE

Do you have Private Health Insurance *with Dental cover*? □ Yes □ No

Fund Name.....Line Ref No.....

Medicare card no……..Ref.no……Expiry date……

Person responsible for accounts (if not self)……..

Are you happy for us to confirm your appointments via SMS on your mobile? □ Yes □ No

If not, would you prefer: □ Email □ Phone

Referring Doctor:

.....

➔ *Please turn over to page 2*

YOUR MEDICAL HISTORY

Please tick "Yes" if you have now, or have had in the past, any of the following:

Heart condition or murmur	□ Yes	□ No	Muscle, bone, joint problems	□ Yes	□ No
Rheumatic fever	□ Yes	□ No	Immune system problems	□ Yes	□ No
High blood pressure	□ Yes	□ No	Gastrointestinal problems	□ Yes	□ No
Bleeding problems	□ Yes	□ No	Urogenital problems	□ Yes	□ No
Respiratory problems	□ Yes	□ No	Liver problems	□ Yes	□ No
Nervous system problems	□ Yes	□ No	Cancer	□ Yes	□ No
Thyroid problems	□ Yes	□ No	Pregnancy	□ Yes	□ No
Diabetes	□ Yes	□ No	Smoking	□ Yes	□ No
Infectious diseases	□ Yes	□ No	Alcohol	□ Yes	□ No
Osteoporosis	□ Yes	□ No	Betel nut use	□ Yes	□ No

Medications……

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Have you ever been prescribed any of the following medications? Zometa™, Pamidronate™, Bonefos™, Actonel™, Fosamax™ .....

Hospital admissions……...

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Allergies…….

..…….

Other……..…

FAMILY DOCTOR'S DETAILS

Doctor's Name……..

Address…….

Telephone…….