QLD OMS

Patient Details Record

Personal Details

Title: Dr Mr Mrs Ms Miss Master Other - _ Preferred Name: _____

First Name: _____ Second Name: _____

Surname: _____ Date of Birth: _____

Home Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Ph: _____ Mobile Ph: _____ Work Ph: _____

Email: _____ *please circle best contact*

Occupation: _____ Employer: _____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Reference Number: ☐ Expiry: ☐☐ / ☐☐

Are you in a health fund for - Private Hospital Cover: ☐ Yes ☐ No Extras Cover: ☐ Yes ☐ No

Name of Fund: _____ Membership Number: _____ Reference Number: _____

Who is responsible for Fees? ☐ Myself Other: _____

Next of Kin: _____ Contact Ph: _____

Other Family Members Treated at QOMS: _____

Medical History

Have you **ever** been diagnosed with any of the following conditions?

Blood Pressure	☐ High	☐ Low	☐ No
Asthma / Lung Disease		☐ Yes	☐ No
Diabetes		☐ Yes	☐ No
Heart Disease / Surgery		☐ Yes	☐ No
Heart Attack or Stroke		☐ Yes	☐ No
Prosthetic Joint eg knee, hip		☐ Yes	☐ No
Cancer		☐ Yes	☐ No
HIV / Hepatitis		☐ Yes	☐ No
Smoker		☐ Yes	☐ No
For Females, are you pregnant?		☐ Yes	☐ No

Please list other **medical conditions**: _____

_____

_____

Please list any **medications** (prescription, over-the-counter, vitamin, or herbal) ☐ Nil

_____

_____

Do you take 'blood thinning' medications?	☐ Yes	☐ No
Have you ever taken any medications for osteoporosis / bone density / bone cancer?	☐ Yes	☐ No
Please list any **allergies:** _____		☐ Nil
Have you ever suffered excessive **bleeding** following a cut or surgical procedure?	☐ Yes	☐ No
Do you require **antibiotics** prior to dental treatment?	☐ Yes	☐ No

Please Turn Over

Are you currently under the care of a general medical practitioner? ☐ Yes ☐ No

Name of Doctor: _____ Suburb: _____

Are you currently under the care of a dental practitioner? ☐ Yes ☐ No

Name of Dentist: _____ Suburb: _____

Are you currently under the care of a specialist medical practitioner? ☐ Yes ☐ No

Name of Specialist: _____ Suburb: _____

I herby consent to the use of this information as set out in the Privacy & Consent Statement below.

Patient / Parent / Guardian Signature: _____ **Date**: _____

Privacy & Consent Statement

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may accurately assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors, specialists, and dentists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

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Oral & Maxillofacial Surgeons

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