Title: Mr/Mrs/Ms/Miss/Other........................ **Date of Birth:** ..../........../....................

Full Name: ....

Phone: Home)...................................Mobile)..................................Work)...........................

Postal address: ....

Home address: ....

Email address: ....@........................... **Occupation:**...

Next of Kin: Name)...Phone)...

Medicare No:(10 digits)...Your ID No..........Expiry Date.................

Veterans Affairs Card No:..Expiry Date..................

Do you have private health insurance?....Y / N........ For Hospital?....Y / N........For Dental?....Y / N.........

Fund Name.....................................Policy No..Your ID No...............

Name of regular GP ....

Medical History - *Please answer **YES** or **NO** if you have, or have had, any of the following:*

Medical Condition	**Y / N**	**Details**
Heart disease		
Rheumatic fever		
Blood Pressure problems		
Excessive bleeding		
Hepatitis		
Asthma/Bronchitis		
Diabetes		
Epilepsy		
Allergies		Penicillin / Codeine / Latex / Tape / Rubber / Iodine / other *(please specify)*..
Operations		
Osteoporosis		*If yes, list any medications you are taking, or have taken in the past* Actonel / Fosamax / Other (*please specify)*.............................. .... Prolia 6 monthly Injections...... YES / NO
Kidney problems		
Do you smoke?		
Other serious illnesses		
List all medications you are taking.		

Does your lifestyle place you in a high risk group for HIV / AIDS? ....Yes/No

Ladies, are you pregnant/breastfeeding?..Yes/No

I understand that full payment of the account is my responsibility. I undertake to pay any further expenses incurred resulting from my default on overdue accounts. I will notify my surgeon of any change in my health or medication.Should further information be needed you have my permission to ask the respective health care provider, who may release such information to you.

SIGNATURE:…………………………………………………..DATE:………….......