maxillofacial
& implant centre

**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.....Membership 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 (Type 1,Type 2) | | |
| HIV / AIDS | | |
| Epilepsy | | |
| Allergies | | Penicillin / Codeine / Latex / Tape / Rubber / Iodine / other *(please specify)*..... |
| Operations (Recent/Major) | | |
| 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/herbal supplements you are taking. | | |

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:.....**

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