



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:

Table with 3 columns: Medical Condition, Y / N, Details. Rows include Heart disease, Rheumatic fever, Blood Pressure problems, Excessive bleeding, Hepatitis, Asthma/Bronchitis, Diabetes (Type 1, Type 2), HIV / AIDS, Epilepsy, Allergies, Operations (Recent/Major), Osteoporosis, 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.

phone: (07) 5437 9898
fax: (07) 5437 9899

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

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