Oral and Maxillofacial Surgery

# New Patient Form

Please email the completed form to reception@womfs.com.au or bring it to your appointment. Thank you.

| | |
|---|---|
| Title | Mobile |
| First name | Phone |
| Last name | Email |
| DOB | Occupation |
| Gender | |

## Indigenous status

Aboriginal Torres Strait Islander Neither

## Residential address

Street

Suburb State Postcode

## Postal address (if different)

Street

Suburb State Postcode

| Medicare | DVA |
|---|---|
| Number | Number |
| Reference | Type |
| Expiry | Expiry |

| Health Insurance | | | Emergency contact |
|---|---|---|---|
| Fund | | | Name |
| Number | | | Mobile |
| Reference | | | Relation |
| Hospital cover | Yes | No | |
| Dental extras | Yes | No | |
| Level of cover | | | |
| Excess if known | | | |

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Weight (kg)

Height (cm)

Smoking Yes Former Never

Do you have the following

| | | |
|---|---|---|
| Allergies | Yes | No |
| Heart conditions including angina or past “heart attack” | Yes | No |
| Lung conditions including asthma | Yes | No |
| Neurological conditions including epilepsy or stroke | Yes | No |
| Diabetes | Yes | No |
| History of hepatitis B or C, HIV, TB, MRSA, VRE, or CRE | Yes | No |
| Blood thinners eg aspirin/warfarin/clopidogrel/rivaroxaban | Yes | No |
| Osteoporosis medications including tablets or injections | Yes | No |
| Previous radiotherapy | Yes | No |
| Steroid medications | Yes | No |
| Prosthetic heart valve | Yes | No |
| Previous rheumatic heart disease | Yes | No |
| Previous infective endocarditis | Yes | No |
| Previous cardiac transplant | Yes | No |
| Congenital heart disease | Yes | No |
| Implants (eg joints, pacemaker, defibrillator, metal) | Yes | No |
| Other medical conditions | Yes | No |
| Medications | Yes | No |

If you ticked “Yes” to any of the above, please provide details below

Signature Name Date

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