Surgident

Patient label

Patient Information

In order to maintain treatment of the highest possible standard it is necessary that the following information be answered accurately. The information you provide on this form will become part of your Medical Record. The Information will remain confidential.

1 Your full name

Title: Mr ☐ Master ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

First name

2 Your date of birth Age

3 Your sex Male ☐ Female ☐

4 Marital status Single ☐ De-facto ☐ Separated ☐ Married ☐ Divorced ☐ Widowed ☐

5 Country of birth

6 Indigenous status Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ European ☐ Asian ☐ Other ☐

7 Language spoken

Interpreter needed? No ☐ Yes ☐

8 Your occupation

9 Your contact details
Residential address

Postal address (if same as your residential address write SAME)

Home telephone

Work telephone

Mobile number

Email address

Preferred method of contact

Home phone ☐ Work Phone ☐ Mobile Phone ☐ Email ☐

10 Who should be contacted in case of an emergency?

Title: Mr ☐ Master ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

First name

Home telephone

Work telephone

Mobile number

Relationship to you (e.g. husband)

11 Your Medicare Number

Your Reference number (i.e. the number in front of your name on the card)

Card valid to:

12 Department of Veterans' Affairs number *(if not applicable, write 'N/A')*

13 Aged Pension number *(if not applicable, write 'N/A')*

14 Is your treatment covered by workers Compensation or Third Party insurance No ☐ Yes ☐

15 Do you have private health insurance?

No ☐ Yes ☐ ▶ Please give details

Name of fund

Membership number

Have you been with the fund for over 12 months? No ☐ Yes ☐

16 Who is responsible for payment of your account?

Self ☐ Parent ☐

Other ☐ ▶ Specify

17 Your referring Dentist's or Doctor's name

18 Have you been at our practice before?

No ☐ Yes ☐ ▶ In what year?

19 Have you been admitted to hospital within the last 28 days?

No ☐ Yes ☐

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20 Please complete the following about your medical history. The information you disclose will only be used in your care and is treated in confidence

a) Do you **smoke**? No ☐ Yes ☐ ▸ How many cigarettes per day? _____

b) Have you **ever smoked**? No ☐ Yes ☐ ▸ When did you quit? _____

c) Do you **drink alcohol**? No ☐ Yes ☐ ▸ How many drinks per day? _____

d) Are you **pregnant**? No ☐ Yes ☐ ▸ How many weeks? _____

e) Have you had **orthodontic treatment**? No ☐ Yes ☐ ▸ When was it completed? _____

f) Are you currently taking **contraceptives**? No ☐ Yes ☐ ▸ Please specify _____

g) Are you currently taking **steroids**? (Prednisolone, inhaled steroids etc.) No ☐ Yes ☐ ▸ Please specify _____

h) Are you currently taking any **anti-clotting** medications e.g. Asprin, Warfarin? No ☐ Yes ☐ ▸ Please specify _____

i) Do you take **recreational drugs**? (Marijuana, speed, ecstasy etc.) No ☐ Yes ☐ ▸ Please specify, and indicate frequency _____

j) Are you currently taking any **other medications**? Please include any antidepressants (e.g. Zoloft), any herbal medications (e.g. Echinacea) and any over the counter drugs No ☐ Yes ☐ ▸ Please specify _____

21 Do you have, or have you ever had ANY of the following? (Please tick ALL that apply)

- ☐ Hypertension
- ☐ Blood clots / DVT
- ☐ Palpitations
- ☐ CVA (stroke)
- ☐ Prolonged bleeding
- ☐ Anaemia
- ☐ MI (heart attack)
- ☐ Angina
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Chest pain
- ☐ Scarlet fever
- ☐ Chronic airways limitations
- ☐ Diseased lungs
- ☐ Asthma / Bronchitis
- ☐ Tuberculosis
- ☐ Sinus / Hay-fever
- ☐ Breathlessness (when walking up stairs)
- ☐ Pneumonia
- ☐ Sleep Apnoea
- ☐ Arthritis
- ☐ Neck / Back pain
- ☐ Joint replacement (e.g. hip)
- ☐ Osteoporosis
- ☐ Gout
- ☐ Peripheral Vascular Disease
- ☐ Diabetes (IDDM) Type 1
- ☐ Diabetes (NIDDM) Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Clotting disorders
- ☐ Blood disorders
- ☐ Bruise easily
- ☐ HIV
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ MRSA (Methicillin Resistant Staphylococcus aureus)
- ☐ Creutzfeldt Jacobs Syndrome
- ☐ Cough / Cold (in the last 2 weeks)
- ☐ Mouth ulcers
- ☐ Glaucoma
- ☐ Stomach ulcers
- ☐ Gastric reflux
- ☐ Indigestion
- ☐ Bowel problems
- ☐ Jaundice
- ☐ Chronic renal failure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Prostate problems
- ☐ UTI recurrent (bladder infections)
- ☐ Epilepsy / fits
- ☐ Headaches
- ☐ Migraine
- ☐ Anxiety / Depression
- ☐ Prone to falls
- ☐ Other - please specify

_____

22 Are you allergic to or had a reaction to ANY of the following? (Please tick ALL that apply)

- ☐ Local anaesthetic (numbing medication)
- ☐ Penicillin
- ☐ Amoxycillin
- ☐ Other antibiotics
- ☐ Sulphur drugs
- ☐ Valium / other tranquilisers
- ☐ Codeine or other narcotics
- ☐ Other medications
- ☐ Latex
- ☐ Soy
- ☐ Eggs / yolk
- ☐ Sulfites
- ☐ Please list any other allergies not listed above

_____

23 Have you ever experienced prolonged bleeding?
No ☐ Yes ☐ ▸

24 Have you ever had to have a blood transfusion?
No ☐ Yes ☐ ▸ In what year? _____

25 Your approximate weight _____ kg

26 Your approximate height _____ cm
OR
_____ feet/inches

27 Where did you hear about us?
Referral ☐ Friend/Relative ☐ Internet ☐ Yellow Pages ☐
Other ☐ ▸ _____

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