HORNSBY OMS
ORAL & MAXILLOFACIAL SURGERY

PATIENT REGISTRATION FORM

PERSONAL DETAILS

Title:	First name:	Middle name:	Surname:
Preferred Name:		Email:	
Date of Birth:	Gender: ❑ M ❑ F ❑ Other	For "Other", preferred pronouns:	
Mobile phone:	Home phone:	Occupation:	
Residential address (including suburb):		Postal address (if different to residential):	

MEDICARE AND PRIVATE HEALTH INSURANCE

Medicare number (10 digits):	Ref:	Expiry:	Name on card (if different to above):
Private health fund name:	Member no:		Number in front of your name:
Type of Cover: ☐ Hospital Cover ☐ Dental Extras			
DVA (Dept Vet Affairs) number:	Card type:		Expiry:

PERSON RESPONSIBLE FOR ACCOUNTS (COMPULSORY FOR PATIENTS UNDER 16)

Name:	DOB:	Phone:	
Address (if different):		Email:	
Medicare number:	Ref:	Expiry:	Name on card:

GENERAL PRACTITIONER

GP name:	Phone:
Practice name and address:	

EMERGENCY CONTACT

Name of emergency contact:	Relationship to patient:	Mobile phone:

MEDICAL HISTORY

☐ Bleeding disorder ☐ Anticoagulation	☐ Diabetes: Type 1 / Type 2	☐ Joint replacement
☐ Prosthetic heart valve	☐ Liver disease/Cirrhosis/Hepatitis	☐ Osteoporosis
☐ Heart murmur ☐ Previous heart surgery	☐ Kidney disease	☐ Steroid therapy
☐ Pacemaker	☐ Neurological disorder	☐ Cancer
☐ Previous heart attack ☐ Angina	☐ Epilepsy	☐ Radiotherapy ☐ Chemotherapy
☐ Congenital heart defect	☐ Stroke/TIA	☐ Gastro-oesophageal reflux
☐ Blood pressure: High / Low	☐ Anxiety disorder ☐ Depression	☐ Smoking: if so, how much? _____
☐ Asthma ☐ COPD	☐ Thyroid disorder	☐ Recreational drugs: _____

Allergies:

Current Medications:

Any other conditions:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any accounts. I authorise Hornsby Oral & Maxillofacial Surgery to release any information required for my treatment or to process any claims. I authorise Hornsby Oral and Maxillofacial Surgery to contact me via SMS and email.

Patient/Guardian signature *Date*