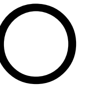

PERTH ORAL MEDICINE & DENTAL SLEEP CENTRE

Title Dr Mr Mrs Ms Miss (Please tick) **Known As** ____________________

First Name ____________________ **Surname** ____________________ **Marital Status** __________

Date of Birth _____ / _____ / _____ **Occupation** ____________________

Home Address ____

Suburb ______________________________ P/code __________

Postal Address ____

Suburb ______________________________ P/code __________

Telephone (M) ____________________ (H) ____________________

Email Address ____

Work Details ____________________ (W) ____________________

Emergency Contact/ Next of Kin Name ____________________ Relationship ____________________

(M) ____________________ (H) ____________________

Medicare No ____________________ Ref __________ Exp _____ / _____

HCC/Pensioner ____________________ Exp _____ / _____

Department of Veteran Affairs ____________________ Colour __________ Exp _____ / _____

Private Health **YES / NO** **Insurer Name** ____________________

General Practitioner ____________________ (W) ____________________

Address ____

Dentist ____________________ (W) ____________________

Address ____

Referred by ☐ General Practitioner ☐ Dentist ☐ Other (Details below)

Name ____________________ (W) ____________________

Address ____

Please Tick	**YES**	**NO**	**DETAILS**
Are you taking any tablets or medications (prescribed or over-the-counter) at present? *Please specify.*			
Do you normally require antibiotic cover for surgical procedures?			
Do you have any known allergies (penicillin, drugs, latex or foods)?			
Have you had any reactions to local or general anaesthesia?			
Do you smoke? *If so, how many per day, and how many years?*			
Are you a past smoker? *If so, how many did you smoke and for how many years? When did you stop smoking?*			
Do you drink alcohol on a regular basis? *If so, how many per day, and for how many years?*			
Do you use mouthwash on a regular basis? *If so, what brand and how many times daily?*			
What brand of toothpaste do you use? How many times a day?			

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Please tick)

	Yes	No		Yes	No		Yes	No
Heart disease			Cancer			Hepatitis or liver disease		
Heart valve disorder			Steroid therapy			Epilepsy		
Rheumatic fever			Diabetes			Muscle disorder		
Cardiac pacemaker			Kidney disease			Anxiety/Depression		
High/low blood pressure			Thyroid disease			Transplant		
Stroke			Stomach or digestive problem			Sexually transmitted disease		
Skin condition			Tuberculosis			Prosthetic joint		
Radiation therapy			Excessive bleeding			Asthma		
Autoimmune disease			Anaemia, Leukaemia or other blood disorder			Bronchitis or lung diseases		
Currently pregnant								
Do you have any other medical conditions? If yes, please list all other medical conditions.								

***Privacy Statement**: We value your privacy. All of the information, which you provide to us, will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is available from our Reception staff. Please speak to one of our staff members if you have any concerns about how we will use your personal information.*

1. Please answer the following questionnaire truthfully and to the best of your ability. If ever your health status or medications change, please inform your practitioner at the next appointment.
2. Practice policy is all accounts are settled on the day, immediately after seeing the practitioner.
3. Please note that Medicare rebates are not available. Rebate for services are only available from Private Health Funds. We do not process Private Health Fund rebates for patients at the rooms.
4. The practitioners are not "preferred providers" of any Private Health Fund and have no control over your rebate received.
5. Patients will be charged for missed and late cancellation appointments unless cancelled 24 hours prior to the consult time. DVA, Workers' Compensation and Motor Vehicle Accident patients will be charged privately for appointments not kept.
6. Some consultations and procedures may not be claimable under Workers' Compensation, Third Party or General Insurance. We will assist you in directing your bills to the relevant insurance body/solicitors for settlement. However, you are ultimately responsible for the account irrespective of any disputes with the insurance companies.
7. Please ensure the above information regarding health practitioners involved in your care is current and complete. Correspondence will be sent to all health practitioners listed unless you advise us otherwise.
8. We would appreciate notification of any change of address.
9. CCTV (video only) operates in these premises for security reasons only and not for patient records.
10. I consent to allow my de-identified clinical information and photographs to be used for educational purposes.

I declare that the particulars and information provided are true and correct, and I understand and agree to the above conditions. Further, I hereby authorise **Perth Oral Medicine & Dental Sleep Centre** and its practitioners, to obtain and release information about my condition to assist in my treatment and/or rehabilitation.

Patient/Guardian Signature ______________________________ Date _____ / _____ / ______

(If under 18 years): Guardian Name ______________________________

Guardian Address ______________________________ Phone ______________________________

Do you have a **Trust Account** or a **Third Party** that settles your account? If yes, please see Reception.

For Office Use Only