OROMAX CLINIC

Incorporating the *ADELAIDE DENTAL IMPLANT SURGICAL CENTRE*

PATIENT INFORMATION

TITLE	Mr / Mrs / Ms /Miss / Master / Dr
GIVEN NAMES	
(Preferred Name)	
SURNAME	
DATE OF BIRTH	
POSTAL ADDRESS	
SUBURB	
POST CODE	
OCCUPATION	
HOME PHONE	
WORK PHONE	
MOBILE	
EMAIL	

ACCOUNT INFORMATION

Please provide details of the person responsible for paying the account if not the same as above.

TITLE	Mr / Mrs / Ms / Dr
GIVEN NAME	
SURNAME	
ADDRESS	
SUBURB	
CONTACT PHONE	

CONSENT

As I am seeking private treatment, I understand that the payment of the account is my sole responsibility. I undertake to pay any additional expenses incurred in recovery of overdue accounts. In the case of a minor this responsibility transfers to the person responsible for the account.
This Practice has a Privacy Policy on handling patient information. You are not obliged to provide any information requested of you, but that failure to do so might compromise the quality of your care. I consent to the handling of my information for the purposes required for my treatment subject to any limitations on access or disclosure, that I notify this Practice of in writing.

SIGNATURE:

DATE:

REFERRAL INFORMATION

REFERRED BY	
USUAL MEDICAL GP	
GP ADDRESS	

CARD INFORMATION

MEDICARE NO	_ _ _ _ / _ _ _ _ _ _ / _
No next to your name	
Expiry Date	_ _ / _ _ _ _
VETERAN NO	☐ White Card ☐ Gold Card

HEALTH INSURANCE INFORMATION

NAME OF HEALTH FUND:

HEALTH FUND MEMBERSHIP NO:

Have you been with this Fund for more than 12 months? **YES / NO**

DO YOU HAVE HOSPITAL INSURANCE? YES / NO

DO YOU HAVE DENTAL EXTRAS? YES / NO

If 'YES' are your Dental Extras with the same fund? **YES / NO**

WORKCOVER INFORMATION

Insurance Company	
Case Manager	
Claim Number	

THIRD PARTY INFORMATION

Solicitor's Name	
Solicitor's Phone No	
Claim No	

PRIVACY INFORMATION

This Practice is committed to protecting the privacy and security of any personal information it obtains from you and recognises that it must abide with the provisions of the Australian Privacy principals under the Commonwealth Privacy Act 1998 and all other state legislative requirements in relation to the management of personal information.
The primary purpose of collecting your information is to provide quality health care. We require your personal details and full medical history so that we may properly assess, diagnose, treat and be pro-active in your health care needs in the following ways:

- Disclosure to others involved in your care, including treating doctors/dentists and specialists outside of this Practice. This may occur through referral to other doctors/dentists or for medical tests and in the reports or results returned to us following the referrals.
- Emergency situations whereby medical officers/hospitals require access to patient notes for treatment purposes.

If you have any questions about how we use the information you provide to us, please speak with your surgeon.

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MEDICAL HISTORY FORM

NAME:		DOB:	UR: *To be completed by Oromax*
Height:	Weight:	BMI: (office use only)	

PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES	NO	YES
Have you had an anaesthetic before?		
Have you or any relative ever experienced complications with an ANAESTHETIC?		
Have you had an operation in the last five years? If yes, please document reason below : …….		
Do you have any neck or jaw stiffness?		
Are you **ALLERGIC** to any drugs, food, tapes, latex or rubber? If yes, give details:		
Have you any reason to believe that you are in a high risk group for hepatitis or HIV (AIDS virus)?		
Do you have any of the following? Hepatitis B, Hepatitis C, HIV, *Please circle* MRSA or VRE		
Is there a possibility that you may be pregnant?		
Do you have any special needs?		
Do you take ASPIRIN regularly, WARFARIN or 'blood thinning' medication?		
Have you had any treatment for excessive bleeding or bleeding disorder?		
Do you have or have had Anaemia?		
Do you have or have had High Blood Pressure?		
Have you had Rheumatic fever?		
Have you had a heart attack or heart problem (including chest pain, ANGINA, heart palpitations)?		
Have you had Heart Surgery? If yes, when? Do you have any of the following: ❒ Pacemaker ❒ Cardiac stents ❒ Heart valve replacement ❒ Other		
Do you have an arm shunt or suffer from Lymphedema of arms?		
Do you suffer from ASTHMA? If yes, do you use a puffer (eg. Ventolin)? YES / NO		
Do you have or have had troublesome shortness of breath, persistent cough or sleep apnoea?		
Have you ever had bronchitis or pneumonia? If yes, when?		
Do you or have you had any kidney disease?		
Are you a diabetic? If yes, Type 1 or Type 2?		
Have you ever had Hepatitis, jaundice or liver problems?		
Do you have stomach or peptic ulcers, Hiatus hernia, reflux, indigestion or heartburn?		
Do you or have you had any psychiatric conditions? (eg: Anxiety, Depression, Other)		
Have you been diagnosed with Autism Spectrum Disorder or Asperger Syndrome?		
Do you suffer from Epilepsy, fits, blackouts or faints?		

PLEASE ANSWER THESE QUESTIONS BY TICKING THE BOXES	NO	YES
Do you suffer from eczema or any other skin condition?		
Have you or any member of your family had or been exposed to infectious/communicable disease in the last 2 weeks? (eg. Flu, shingles, measles)		
Do you require assistance with walking?		
Do you smoke? If yes, what is your daily amount? …………………….		
Do you drink alcohol? If yes, what is your daily amount? …………………….		
Do you use or have used in the past year any recreational drugs?		
Have you had any other serious illness?		
Any further comments?		
List names/doses of all TABLETS/MEDICINES you are currently taking (including un-prescribed drugs/herbal/ complimentary medicines):		
How do you plan to get home when you are discharged?		
Where will you be staying the night of your surgery?		

For patients who will have intravenous sedation at Oromax Day Surgery:

Following surgery, I will have a responsible adult drive me home. I realise that mental impairment may persist for several hours following the administration of anaesthesia. I will avoid making decisions or taking part in activities which may depend upon full concentration or judgement for 24 hours.

For all patients:

I will follow discharge instructions and attend appointments as advised. The answers I have given to all questions are true to the best of my knowledge.

*Signed*______________________________________ *Date*____________________

PREADMISSION ASSESSMENT
(Surgeon to complete)

❒ Dr Robinson ❒ Dr Doddridge ❒ Dr Sambrook
❒ Dr Collum ❒ Dr Carter ❒ Dr Candy

ALERT (Red Wrist Band): YES / NO

DETAILS OF ALERT:

PREADMISSION CHECK (RN to complete)

Initials:……………………. Date…………………………………

MANAGEMENT PLAN:

FURTHER FOLLOW UP REQUIRED: YES / NO IF YES:

❒ Refer for Pre-Anaesthetic Check

❒ Refer to General Practitioner

❒ Other:……

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