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# ADMISSION FORM

OMFS
ORAL & MAXILLOFACIAL SURGEONS

| **Patient Details** | Title: | Surname: | | |
|---|---|---|---|---|
| Given name: | | Preferred name: | Date of birth: | Age: |
| Residential Address: | | Suburb: | | Postcode: |
| Postal Address (if different to above): | | | | |
| Telephone Home: | | Telephone mobile: | Occupation: | |
| **May we use SMS to communicate with you (or your parent/carer) regarding your appointment?** | | | | **YES / NO** |
| Email: | | | | |

| **Medicare** | Patient's Medicare no.: | Ref no.: (The # next to patient name) | Expiry: |
|---|---|---|---|

| **Insurance Details** | Do you have private health insurance? **YES / NO** | Dental extras? **YES / NO** Hospital cover? **YES / NO** Have you been covered for more than a year? **YES / NO** |
|---|---|---|
| Health fund name | | Member no.: |
| Are you eligible for: TAC WORKCOVER | Claim number: | Name and phone of Claim manager: |

| **Emergency Contact** | Full Name: | Relationship: | Telephone: |
|---|---|---|---|

| **Bill Payer Details** | **Only complete this section if someone OTHER than the patient is responsible for the account** |
|---|---|
| Bill payer's full name: | |
| Bill payer's postal address | Bill Payer's phone number: |
| Bill payer's email: | |

| **Referrer Details** | Name: | Suburb: |
|---|---|---|
| General Practitioner's name: | Suburb: | Phone: |
| General Dentist's name: | Suburb: | Phone; |

Do you have any other medical specialists involve with your care? (E.g. cardiologist, endocrinologist etc.)
If yes, please provide their details below

| Name: | Specialty |
|---|---|
| Suburb | Telephone |

***Continued on other side →***

| **Medical History** – please tick if you have ever had: | | | | | |
|---|---|---|---|---|---|
| Any heart conditions | Yes ❑ | No ❑ | Hepatitis | Yes ❑ | No ❑ |
| Blood pressure irregularities | Yes ❑ | No ❑ | Hay fever or Sinus | Yes ❑ | No ❑ |
| Rheumatic Fever | Yes ❑ | No ❑ | Asthma | Yes ❑ | No ❑ |
| Diabetes | Yes ❑ | No ❑ | A Bleeding Disorder | Yes ❑ | No ❑ |
| Epilepsy | Yes ❑ | No ❑ | Are you pregnant? Yes ❑ No ❑ How many weeks: | | |
| Certain groups are at a high risk of being infected with the HIV, Hep B and Hep C virus. Are you in such a group? | | | | Yes ❑ | No ❑ |
| Are you in a high risk group for Creutzfeld-Jacob Disease (CJD)? | | | | Yes ❑ | No ❑ |
| Are you, or have you ever been, a smoker? | Yes ❑ | No ❑ | If yes, how many cigarettes do you smoke per day? | | |
| Do you have an allergy to any medications, rubber or other?<br>If YES, please list: | | | | Yes ❑ | No ❑ |
| Are you taking any medication for osteoporosis, or taking Fosamax or Actonel? | | | | Yes ❑ | No ❑ |
| Are you currently receiving treatment for any medical condition?<br>If YES, please list: | | | | Yes ❑ | No ❑ |
| Are you taking ANY medications at all?<br>If YES, please list: | | | | Yes ❑ | No ❑ |
| Are there any other aspects of your Medical or Dental history that should be brought to our attention?<br>If YES, please list: | | | | Yes ❑ | No ❑ |

## Your Health Information and Our Privacy Policy

*In accordance with the Australian Privacy Principles contained in the Commonwealth Privacy Act 1988 (Privacy Act) and applicable State legislation*

OMFS respects your right to privacy and thus has systems and processes in place to ensure it complies with the Australian Privacy Principles. This statement is a summary of the practice's privacy policy. The complete policy is available in the waiting room or upon request.

OMFS collects information about you for the purpose of providing health services to you. Personal information such as your name, address and health insurance details are used for the purpose of addressing accounts and sending relevant correspondence, as well as processing payments and writing to you about our services and any issues affecting your health care.

OMFS may disclose your health information to other health care professionals or third parties, or require it from them if, in our judgement, it is necessary in the context of your care. Your health information may also be used for research purposes, in study groups or at seminars; however, in such situations, your personal identity will not be disclosed without your consent.

You may choose not to provide OMFS with information relevant to your care. In this instance OMFS may not be able to provide a service to you, or the service we are asked to provide may not be appropriate for your needs. Importantly, if you do not provide information that may be relevant to your care or that is otherwise requested by OMFS, you could suffer some harm or other adverse outcome.

Your medical history, treatment records, x-rays and any other material relevant to your care will be stored by OMFS. The privacy policy sets out how you can access your records or seek correction of your records. It also specifies how you can report suspected privacy breaches and how OMFS will deal with such a situation.

As part of its electronic records system, OMFS may rely on cloud storage providers located outside Australia. OMFS will comply with its obligations under Australian privacy laws in relation to all offshore storage situations.

The OMFS Business Manager can be contacted at the practice during business hours on 03 9347 3788 or emailed at businessmanager@omfs.com.au if you have any concerns or questions about a privacy matter.

Please sign this form as confirmation that you have read and understood our Privacy Policy, and consent to the use of your information in the ways outlined.

Signed: _____ Dated: _____ / _____ / _____

*(if patient is under 16, parent or guardian must sign on their behalf)*

Patient / Parent /Guardian Name: _____