**
PATIENT INFORMATION**

**Surname: Given Names:**

**Title: Dr / Mr / Mrs / Ms / Miss / Master/ Sex: M / F DOB:** \_\_\_ / \_\_\_ /\_\_\_

**Address:**

 **Postcode**

**Phone: (H) (W) (M)**

**Email:**

**Next of Kin:**   **Phone Number/s:**

**Medicare No:** |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| |\_\_| **Expiry: / Reference** |\_\_|

**Are your bank details registered with Medicare ? Please circle: Yes No Unsure**

**Health Fund: Membership No:**

**Dept. Veterans’ Affairs No:** |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| **DVA Card Colour: Expiry: / /**

**MEDICAL HISTORY:**

**Current Regular Medications:**

**Allergies:**

**Do you take any blood thinners or Aspirin regularly?**

**Do you take any medication for your bones?**

**Have you had radiotherapy treatment to your jaw bones?**

**Ladies are you pregnant?**

**Have you had any joint replacements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of replacement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF FEES / PAYMENT:**

**All consultation fees are to be paid on the day of consultation (by either EFT, Visa and Mastercard)**

**All surgical fees need to be paid 1 week prior to surgery to avoid your procedure being cancelled.**

**The above information is correct to the best of knowledge and I understand the conditions of payment.**

**Signature of Patient: Date:** \_\_\_ / \_\_\_ / \_\_\_

**Name of Parent / Guardian:
(If patient is under 18)**

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**CONSENT TO COLLECT PATIENT’S INFORMATION**

**Due to recent changes in the Privacy Laws, a person’s written consent is now required for a health professional to obtain medical information about them and to be able to communicate that medical information about them to another medical practitioner.**

**Due to these changes, the following form will need to be signed if you are happy for Dr Shannon Webber to obtain such information and to liaise with other health practitioners concerning your condition.**

 **Give permission for Dr Shannon Webber to:**

1. **Obtain medical information about me from other medical practitioners, including consultation notes and results of tests or investigations performed by other medical practitioners that pertain to my medical condition.**
2. **Communicate with other health professionals directly involved with my medical condition.**
3. **Communicate with the referring medical practitioner concerning my medical condition.**
4. **I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in advertising, scientific papers or demonstrations.**

**I (Name): Date of Birth:**  \_\_\_ / \_\_\_ /\_\_\_\_\_\_

**Address:**

 **Postcode**

**Signed:**