Precision OMS
ORAL & MAXILLOFACIAL SURGERY

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Confidential Patient Registration Form

Welcome to our practice. For our confidential records and to assist in determining your treatment, please answer the following questions as accurately as possible.

Fees are the responsibility of the patient, parent or guardian. Consultations and surgical procedures in the rooms are required to be paid at the time of your visit.

Please complete the below form and forward it to us.

Patient details

Title: | **Given name:** | **Surname:**

Date of Birth:

Address:

Phone number: | **Mobile number:**

Email address:

If the patient is under 18 years of age, please specify:

Mother / Guardian

Given name: | **Surname:**

Father / Guardian

Given name: | **Surname:**

Person responsible for account (if not the patient)

Given name: | **Surname:**

Address:

Phone number: | **Email address:**

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ORAL & MAXILLOFACIAL SURGERY

Emergency contact

Given name:

Surname:

Relationship to patient:

Address:

Phone number:

Medicare

Medicare number:

Reference number:

Private health insurance

Name of private health insurance:

Membership number:

Please specify level of cover (please circle): Extras Dental Cover / Private Hospital

Type of Private Hospital cover (please circle): Gold / Silver / Bronze / Basic

Period of membership (please circle): Less than 12 months / More than 12 months

Other eligibility

Department of Veteran Affairs card number:

Card colour:

Are you eligible for (please circle): TAC / WorkCover

Please specify:

Claim number:

Company:

Case worker:

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ORAL & MAXILLOFACIAL SURGERY

Medical GP / Clinic contact details

Doctor's name:

Practice / Clinic name:

Address:

Phone number:

Dentist / Clinic contact details

Dentist's name:

Practice / Clinic name:

Address:

Phone number:

Disclosure authorisation

We respect your privacy and will not disclose any information to anyone without your prior approval unless it is clinicians and hospitals directly involved with your treatment / care.

I give authorisation for disclosure of my records or treatment with the following next of kin(s):

Given name:

Surname:

Relationship:

Given name:

Surname:

Relationship:

Signature:

Date:

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Medical history

How much do you weigh (kg)?:

How tall are you (cm)?

(This information guides fitness for procedure decisions).

Have you received all of the required COVID-19 vaccinations? **Yes / No**

Have you had COVID-19? **Yes / No**

If yes, when?

Have you ever had any heart related problems (eg. AMI, Stents, Valve Replacement)? **Yes / No**

Please specify:

Have you ever had any breathing / lung related problems? **Yes / No**

If yes, please circle: Asthma / Bronchiectasis / Bronchitis / Emphysema / Sleep Apnoea

Are you a smoker? **Yes / No**

If yes, how many per day?

Do you have any bleeding or clotting disorders? **Yes / No**

Have you ever had prolonged bleeding from dental procedures? **Yes / No**

Do you take any blood thinners? **Yes / No**

If yes, please circle: Aspirin / Clopidogrel / Pradaxa / Warfarin / Xarelto / Other

If other, please specify:

Do you get acid reflux into your mouth or have you had stomach ulcers? **Yes / No**

Do you regularly experience anxiety? (This background might suggest the appropriate treatment format) **Yes / No**

During dental procedures, do you have an issue with a gag reflex? **Yes / No**

Do you have diabetes? **Yes / No**

If yes, please circle: Type 1 / Type 2 / Insulin Resistance

Do you take insulin? **Yes / No**

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Blood Pressure (please circle): Low / Normal / High

Are you taking medications? **Yes / No**

If yes, please specify:

Do you take medication for osteoporosis? **Yes / No**

If yes, please circle: Fosamax / Prolia / Zometa / Other

If other, please specify:

Do you have any joint replacements? **Yes / No**

If yes, please circle: Hip / Knee / Shoulder

Year inserted, please specify:

Have you ever been exposed to an infectious disease? **Yes / No**

If yes, please circle: Hepatitis B / Hepatitis C / HIV / Rheumatic Fever / Scarlet Fever / Other

If other, please specify:

Have you ever had a problem with any type of anaesthetic? **Yes / No**

If yes, please circle which type: General Anaesthetic / Intravenous Sedation / Local Anaesthetic

Please specify:

Are you pregnant or breast feeding? **Yes / No**

Do you have any allergies (eg. medication, latex, food)? **Yes / No**

If yes, please specify:

Do you take any regular medications (eg. aspirin, contraceptives, herbal, vitamins)? **Yes / No**

If yes, please specify:

Do you have any other medical conditions not specified above? **Yes / No**

If yes, please specify:

Rarely, ambulance transfer to a nearby hospital may be required (eg. for anaphylaxis).

Do you have ambulance cover? **Yes / No**

If no, do you accept the associated ambulance costs in the unlikely event it is required? **Yes / No**

Office: if sedation is required, please forward a copy to the anesthetist at least 24 hours prior.