Specialist OMFS

INFORMATION SHEET

ORAL & MAXILLOFACIAL SURGERY
SPECIALIST
FACE . TEETH . JAWS

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

FIRST NAME:	SURNAME:
PREFERRED NAME:	DATE OF BIRTH:
OCCUPATION:	HAVE YOU BEEN TO THIS CLINIC BEFORE? YES ☐ NO ☐
HOME ADDRESS:	SUBURB:
POST CODE: EMAIL:	
HOME PHONE NO: WORK:	MOBILE:
MEDICARE NO: ☐☐☐☐ ☐☐☐☐☐☐	REF ☐ EXPIRY DATE:
PAYEE'S DETAILS **(if different to the patient, for claiming rebate purposes)** NAME:_____ SURNAME:_____ DOB: _____ ADDRESS:_____ MEDICARE NO:_____	
DO YOU HAVE PRIVATE HEALTH INSURANCE? YES ☐ NO ☐	DATE JOINED: _____
NAME OF PRIVATE HEALTH FUND:	DO YOU HAVE HOSPITAL COVER? YES ☐ NO ☐
MEMBERSHIP NUMBER:	ANCILLARY COVER (DENTAL, OPTICAL etc)? : YES ☐ NO ☐
DEPARTMENT OF VETERAN AFFAIRS CARD NO: (If applicable)	GOLD ☐ WHITE ☐ BLUE ☐
NEXT OF KIN NAME:	RELATIONSHIP TO PATIENT:
ADDRESS:	CONTACT NUMBER:
HAVE YOU BEEN ADMITTED IN A HOSPITAL IN THE LAST 12 MONTHS? YES ☐ NO ☐	
NAME OF HOSPITAL:	REASON/PROCEDURE:

I, the above patient, consent to the collection and use of the above information, and all further information requested by and given to staff of Clinical A/Professor Dieter Gebauer during this and all subsequent consultations, to help provide an accurate medical diagnosis and to facilitate treatment, including correspondence to my referring/family doctor.

Signed: _____ Name:_____ Date_____

WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENT PATIENTS ONLY

DATE OF ACCIDENT:	CLAIM NUMBER:
INJURY:	EMPLOYER:
EMPLOYERS INSURANCE CO:	CONTACT NO OF EMPLOYER:
HOW INJURY OCCURRED:	WHERE INJURY OCCURRED:

DECLARATION:

I will be responsible for payments of all accounts incurred by me in the event that liability is denied or placed in dispute by the Worker's Compensation Insurance or by the MVA Insurance. I consent all information regarding my treatment to be disclosed to my Employer and Employers Insurance company.

Signed: _____ Name:_____ Date_____

HEALTH HISTORY QUESTIONNAIRE

SPECIALIST FACE . TEETH . JAWS **Your Surgeon is a Medical Practitioner so full disclosure will ensure your best care.** SPECIALIST FACE . TEETH . JAWS

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME OF PATIENT: **DOB:**

Are you currently undergoing treatment with a GP or specialist?	Yes ☐ No ☐
If so, please explain briefly: Name of Dr and practice (if different to GP):	
Date of last appointment with GP:	
GP Doctors Name:	Clinic name:
Address:	
Suburb: Postcode:	Doctors Telephone Number:

PERSONAL HEALTH HISTORY

If you have been admitted to any hospital outside WA/Australia within the last 12 months please let our staff know

Have you recently had the cold or flu? Yes ☐ No ☐

Past Surgical Procedures

Procedure	Year	Hospital

List your prescribed drugs and over-the-counter drugs

Medication	Strength	Time Taken

Allergies to medications or substance	Reaction you had
Penicillin	
Pain Killers	
Iodine	
Latex	
Other (please list)	

MEDICAL HISTORY QUESTIONS

Have you ever suffered from (tick or cross)	YES	NO
Bronchitis, asthma or other chest conditions		
Fainting, giddiness, blackouts or epilepsy		
Heart problems e.g. angina, congenital heart disease/ valvular heart disease/ rheumatic fever		
Diabetes - Type 1, 2 or gestational		
Abnormal blood pressure (High or Low)		
A bad reaction to general or local anaesthetic (i.e. post-operative nausea)		
Blood disorder/prolonged bleeding/blood thinning medication		
Liver Disease (e.g. Jaundice, Hepatitis) or Kidney disease		
Cancer		
Prosthetic joint/transplant surgery/pacemaker/ artificial heart valve		
If you answered yes to any of the above please give a brief explanation.		

Are you Currently		
Receiving treatment from a doctor, hospital or clinic		
Have you had Lap Band Surgery/bariatric surgery		
Having radiation therapy to head or neck		
Have you ever been on a (IV or Oral) Bisphosphonate (used to prevent loss of bone mass) If so, Please give details of length of treatment:		
Taking the contraceptive pill		
Pregnant or possibly pregnant		
Breast feeding		
Receiving Chemotherapy		
Having Corticosteroid Treatment (long Term)		

Tobacco	Do you use tobacco?			Yes	No
	Cigarettes …….. pks./day	Other			
	Have you given up? YES …….. of years				
Alcohol	Do you drink			Yes	No
	…….. Units per day	……. Units per week			

Weight _____kgs **For anaesthetic purposes we need to know the weight of all patients**

Is there anything you think your surgeon should be aware of that is not on this form?

I, the above patient, have been truthful and answered all questions to the best of my knowledge and I consent to the collection and use of the above information, and all further information requested by and given to staff of Clinical A/Professor Dieter Gebauer during this and all subsequent consultations, to help provide an accurate medical diagnosis and to facilitate treatment, including correspondence to my referring/family doctor

Signed: _____ Name: _____ Date:_____