ADVANCED
ORAL & MAXILLOFACIAL SURGERY

PATIENT DETAILS

PERSONAL DETAILS		REFERRAL INFORMATION
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:		Referred by:
Family Name:		Usual GP:
Given Name:		**ENTITLEMENTS**
Date of Birth:		***MEDICARE***
Gender: ☐ Male ☐ Female ☐ Other		Medicare Card Number:
Occupation:		Reference number:
Nationality:		Expiry Date:
Language spoken at home:		For parents who are the claimant for the Medicare rebate:
Do you require an interpreter? ☐ Yes ☐ No		Parent's name:
Do you identify as Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes If yes, ☐ Aboriginal ☐ Torres Strait Islander ☐ both Aboriginal and Torres Strait Islander		Parent's Date of Birth: / Ref. No
		DEPARTMENT OF VETERANS AFFAIRS (DVA)
		DVA Card No.
Residential Address:		**Card Colour:** White ☐ Gold ☐
Suburb:		How will you claim for this admission? (Tick one box only)
State:	**Postcode**:	☐ Private Health insurance (see section A below)
Postal Address (if Different):		☐ DVA
Suburb:		☐ Uninsured – complete section B
State:	**Postcode:**	**SECTION A: PRIVATE HEALTH INSURANCE**
Email:		Name of Fund:
Telephone: Home:		Membership Number:
Business:		**Dental extras:** ☐ Yes ☐ No
Mobile:		**Hospital Cover:** ☐ Yes ☐ No
Preferred contact Number for pre-operative/Post-operative phone call:		**Table:** Bronze ☐ Silver ☐ Gold ☐
Preferred time:		**Length of membership on this table** ☐ **Over 12 months** ☐ **less than 12 months**
SECOND PERSON CONTACT		**Co-payment** (if applicable): $
Name:		**Are you aware of the excess?** ☐ Yes ☐ No
Relationship to patient:		*All excesses attached to your health fund are to be paid on the day of surgery and are an out-of-pocket expense (not rebatable)*
Address:		
Suburb:		**SECTION B: PAYMENT OF ACCOUNT**
State:	**Postcode:**	By signing this form, I acknowledge that:
Telephone Contact:		☐ the information on this form is true & correct to the best of my knowledge
Person responsible for the account		☐ I understand the costs are estimates only & subject to change as a result of variations in the actual treatment received.
Patient: ☐ YES ☐ NO *If no see below…*		☐ I understand other service providers may be involved in my care & this estimate does not include those fees
Name		☐ It is my responsibility to confirm with my health insurer the level of cover held
Relationship to patient		☐ I accept responsibility for full payment of all accounts for hospital fees & charges not funded by my insurer, & will finalise payment at the time of admission.
Telephone		
Signature of Patient/Parent/Guardian:		**Name of Patient/Parent/Guardian:** **DATE:**

PLEASE PRINT CLEARLY AND ENSURE ALL QUESTIONS ARE COMPLETED

Patient Full Name

Address:

Postcode:

Date of Birth:

Have you ever had a reaction to:
DRUGS: ☐ YES ☐ NO Details:

FOOD: ☐ YES ☐ NO Details:

LATEX: ☐ YES ☐ NO Details:

OTHER: ☐ YES ☐ NO Details:

RESPIRATORY

Are you a smoker? ☐ YES - **How many /day?** _____ ☐ NO
Ex-smoker? ☐ **Yes** **When ceased?**_____

Do you have asthma? ☐ YES ☐ NO

Do you have or suffer from bronchitis? ☐ YES ☐ NO

Do you have hay fever? ☐ YES ☐ NO

Do you have emphysema? ☐ YES ☐ NO

Do you have Sleep Apnoea? ☐ YES ☐ NO

Do you use a nebuliser, puffer or EPAP/CPAP machine or home oxygen? ☐ YES ☐ NO
Please bring puffers with you.

Have you ever had throat / nose/lung surgery? ☐ YES ☐ NO

DIABETES

Do you have diabetes? ☐ YES ☐ NO
If yes ☐ Type 1 ☐ Type 2 ☐ Unsure
Controlled by: ☐ Diet ☐ Insulin ☐ Tablet

If you take insulin has your doctor given you instructions regarding your diabetic medication before surgery?
☐ YES ☐ NO if no please call them for advice.

GASTROINTESTINAL (GI)

Do suffer from reflux or heart burn? ☐ YES ☐ NO

Do you have hiatus hernia/GI ulcers? ☐ YES ☐ NO

Do you have specific dietary requirements? ☐ YES ☐ NO

Do you have a gastric band in place? ☐ YES ☐ NO

PROSTHESIS/AIDS

Do you wear glasses/contact lenses? ☐ YES ☐ NO

Do you have a hearing aid or other device ☐ YES ☐ NO

Do you have any Dentures/Caps/Crowns/Loose teeth? ☐ YES ☐ NO

What is your Weight? **Kgs**

What is your Height? **Cms**

Have you had an anaesthetic before? ☐ YES ☐ NO

Have you or any blood relatives had problems with anaesthesia in the past? ☐ YES ☐ NO

PREVIOUS SURGERY
Have you had any previous operations? ☐ YES ☐ NO
Details:

CARDIAC

Have you ever had a heart attack? ☐ YES ☐ NO
if yes, year

Have you ever had heart surgery? ☐ YES ☐ NO
If yes, year

Do you have a pacemaker/internal defibrillator ☐ YES ☐ NO
Make: Model: Last Checked:

Do you have a prosthetic valve? ☐ YES ☐ NO

Do you have cardiac stents? ☐ YES ☐ NO

Do you suffer from angina? ☐ YES ☐ NO

Do you use Glycerol Trinitrate patches? ☐ YES ☐ NO

Do you use sublingual spray (please bring) ☐ YES ☐ NO

Do you have any other heart problems? ☐ YES ☐ NO
If yes specify:

Do you have palpitations? ☐ YES ☐ NO

Do you have an irregular heart beat? ☐ YES ☐ NO

Have you had Rheumatic fever? ☐ YES ☐ NO

Do you have a tendency to bleed, clot or bruise easily? ☐ YES ☐ NO

Do you have high blood pressure? ☐ YES ☐ NO

SKELETAL / MOBILITY

Do you have Back/Neck/Jaw problems? **Circle which**

Have you ever had back/neck/jaw surgery? Circle which

Do you have arthritis? ☐ YES ☐ NO

Have you experienced dizziness, fainting or fallen in the last 12 months? ☐ YES ☐ NO

Do you use a walking aid? ☐ YES ☐ NO
If yes which: ☐ walking stick ☐ crutches ☐ walking frame

Do you have problems weight-bearing? ☐ YES ☐ NO

Do you use a wheelchair? ☐ YES ☐ NO

Do you have any artificial joints or limbs? ☐ YES ☐ NO

Do you have any metal plates or pins? ☐ YES ☐ NO

AFFIX PATIENT LABEL HERE

OTHER	**MEDICATIONS** *(A printout from your GP is sufficient)*
Have you ever tested positive to Hepatitis A, B or C, HIV, TB, MRSA, VRE, or CRE? ☐ YES ☐ NO **Please specify if yes:**	**Do you take any blood thinning/arthritis medication?** (e.g. warfarin, Plavix, aspirin, Xarelto) ☐ YES ☐ NO **Name of medication:** **Have you been instructed to cease/hold this medication?** ☐ YES ☐ NO Date last taken: / / Still taking? ☐ YES ☐ NO **If NO please call your doctor for advice as these medications may need to be stopped prior to treatment**
Do you have an intellectual disability? ☐ YES ☐ NO	
Do you have Alzheimer's/Dementia? ☐ YES ☐ NO	
Female patients, could you be pregnant? ☐ YES ☐ NO **Number of weeks:**	
Do you drink alcohol? ☐ YES ☐ NO **Daily amount?**	**List any medications you take** (prescription, non-prescription including herbal – krill oil, echinacea, olive leaf, vitamins, recreational)
Have you ever had a stroke? ☐ YES ☐ NO **Date:** **Residual effects:**	
Do you suffer from skin conditions? ☐ YES ☐ NO **If yes give details:**	
Do you currently have any skin wounds, pressure sores or ulcers? ☐ YES ☐ NO **Please specify:**	
Have you had a recent cold, flu or unexplained temperature? ☐ YES ☐ NO	
Do you have or have you been exposed to an infectious disease in the past 14 days? ☐ YES ☐ NO **Please specify:**	**FOR PATIENTS WHO WILL HAVE IV SEDATION**
Do you have any other medical or surgical problems? **(e.g. epilepsy, liver, kidney, psychiatric)** ☐ YES ☐ NO **Please specify:**	☐ Following surgery, I will have a responsible adult drive me / accompany me home. I recognise 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 on full concentration or judgement for 24 hours **Signed:** **Date: / /**

FOR ALL PATIENTS

☐ The answers I have given to all questions above are true to the best of my knowledge and I have not withheld any information. I agree to Advanced Oral and Maxillofacial Surgery collecting and using this personal information about me for the planning of my care.

Signed:

Date: / /

If you require assistance or have any questions regarding admission procedures, completion of forms, costs or health insurance status, our staff will be happy to assist you.