WELCOME to....

VICTORIAN ORAL MEDICINE SPECIALISTS

PATIENT REGISTRATION FORM

Title: _____

First Name: _____

Surname: _____

Preferred Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Occupation: _____

Contact No: _____

Email: _____

Emergency Contact/ Next of Kin name: _____

Relationship: _____

Contact No: _____

Medicare No: _____

Ref: _____

What is your reason for referral?

_____

_____

_____

Referring Clinician: Name and Profession (Dentist/ GP/Specialist)

(please nominate your preferred health team member to receive correspondence)

HEALTH QUESTIONNAIRE:

ALLERGIES: List any Allergies (drug/ food/ medicine) **and** type of Reactions:

Smoking history: Current smoker? Ex-smoker? Never?

How many cigarettes per day? _____ For how long? _____ When did you quit? _____

Alcohol drinking: Estimate drinks per week? _____

VICTORIAN ORAL MEDICINE SPECIALISTS

HEALTH QUESTIONNAIRE (continued):

Do you have or have ever had, any of the following medical conditions? (please tick)

	Yes	No		Yes	No
Heart Disease			Stomach or Digestive Problem		
Heart Valve Disorder			Tuberculosis		
Rheumatic Fever			Excessive Bleeding		
Cardiac Pacemaker			Anemia, Leukemia, or Other Blood Disorder		
High/Low Blood Pressure			Hepatitis or Liver Disease		
Stroke			Muscle Disorder		
Skin Condition			Anxiety or Depression		
Radiation Therapy			Transplant		
Autoimmune disease			Sexually Transmitted Disease		
Cancer			Prosthetic Joint		
Steroid Therapy			Asthma		
Diabetes			Bronchitis or Lung Disease		
Kidney Disease			Osteoporosis		
Thyroid Disease			Currently Pregnant		

Do you have any other medical conditions? If yes, please list all other medical conditions.

List all regular medications:

VICTORIAN ORAL
MEDICINE SPECIALISTS

Privacy Statement: We value your privacy. All of the information which you provide to us, will be held and used by us in accordance with our Privacy Policy.

1. Please answer all questionnaires on this form truthfully and to the best of your ability. **If ever your health status or medications change, please inform your practitioner at the next appointment.**
2. Victorian Oral Medicine Specialists is a private billing clinic, our practice policy is for all accounts are settled on the day, immediately after seeing the practitioner. We accept CASH (except for phone reviews), CREDIT or EFTPOS cards. If an account is not paid on the day of consultation a $10 weekly account keeping fee will be incurred.
3. We endeavor to provide the most accurate quotes but this may not always be possible. Please discuss with the individual practitioner if seeking payment plans.
4. Please note that Medicare rebates are not available. Rebate for services are only available from Private Health Funds. **We do NOT process Private Health Fund rebates for patients at the clinic.** The practitioners are not "Preferred Providers" of any Private Health Fund and have no control over your rebate received.
5. Patients will be charged for missed and late cancellation appointments unless cancelled 24 hours prior to the consultation time.
6. Some consultations and procedures may not be claimable under Workers' Compensation, Third Party or General Insurance. We will assist you in directing your bills to the relevant insurance body or solicitors for settlement. However, you are ultimately responsible for the account irrespective of any disputes with the insurance companies.
7. Please ensure the above information regarding health practitioners involved in your case is current and complete. **Correspondence will be sent to all health practitioners listed unless you advise us otherwise.**
8. We would appreciate notification of any change of address or contact numbers or emails.
9. I consent to allow my de-identified clinical information and photographs to be used for educational purposes.

I declare that the information provided is true and correct, and I understand and agree to the above conditions. Further, I hereby authorize Victorian Oral Medicine Specialists (VOMS) and their practitioners, to obtain and release information about my condition to assist in my treatment and/ or rehabilitation.

Patient/ Guardian Signature:

Date:

(if under 16 years)

Guardian Name:

Contact No.: