VICTORIAN
ORAL & FACIAL SURGEONS

Dr. Sam Verco
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Oral and Maxillofacial Surgeons

Patient Registration Sheet

Mr / Mrs / Ms / Miss / Other (Circle One)

First Name..... Surname.....

Street Address..... Suburb..... State..... Postcode .....

Date of Birth..... Email Address.....

Home Phone..... Work Phone..... Mobile.....

Medicare Number..... Number Next to your name on card.....

Private Health Fund..... Membership No..... Ref.....

Hospital Cover: Yes/No (Circle one) Dental Cover: Yes/No (Circle one)

Vet Affairs No.....White/Gold (Circle one) Health Care/Pension Card No.....

Usual GP..... GP Contact No.....

Usual GP Address.....

Dentist..... Address.....

Occupation..... Name of person responsible for fees (or self).....

Emergency Contact..... Relationship..... Mobile.....

DO YOU HAVE ANY OF THE FOLLOWING?

□ Asthma	□ Diabetes	□ Emphysema	□ Epilepsy
□ Heart Conditions	□ Hepatitis	□ HIV/HIV Related Disease	□ Excess Bleeding
□ Rheumatic Fever	□ Smoker □ Pregnant	□ Blood pressure-High Low	□ Pacemaker

List Allergies.....

List and major operations or other serious illnesses and year.....

List your current medications & dosage.....

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List any problems with general anaesthetic.....

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CONSENT TO COLLECT PATIENT INFORMATION This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following way:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and health insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice a advised by you.

*I understand that I am not obligated to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
*I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld.
*I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
*I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify.

Signature..... Date.....