DR ANTHONY CROMBIE
ORAL AND MAXILLOFACIAL SURGERY

CONFIDENTIAL PATIENT INFORMATION

PERSONAL DETAILS

Ms/Miss/Mrs/Mr/Master/Dr/Other______________ Date of birth: ___ /____ /____
Given name: __________________________Surname: ______________________________________
Known As: ____
Address:____
Postal Address (if different to above):____
Phone: Home __________________ Work ____________________ Mobile______________________
Email: ____

CLAIM DETAILS

Private health insurance: Dental: Yes / No Hospital: Yes / No **(please circle)**
Fund name: ____ Membership No.:________________
Medicare number: ☐☐☐☐☐☐☐☐☐☐ Ref no. next to name: ☐ Exp date: ____/____
Are your bank account details registered with Medicare? Yes / No **(please circle)**
Dept. Veterans Affairs Card #: ______________________ White ___ Gold ___ Exp date: ____ /____
WorkCover (if applicable) Claim #: _________________________ Insurer: ________________________

ACCOUNT HOLDER DETAILS

Who is responsible for your account? **(if not you, then please fill out details below**)
Name: Mr/Mrs/Ms/Dr ____DOB: ___/ ___/___
Medicare number: ☐☐☐☐☐☐☐☐☐☐ Ref No. next to name: ☐ Exp date: ____/____
Are your bank account details registered with Medicare? Yes / No
Email Address:_________________________________ Phone number:_________________________

PRIVACY

Are you happy for communication to be sent to you family doctor or General Practitioner? Yes/No

General Practitioner's details (only complete this section if your GP was not your referring doctor)
Name: ____
Practice address: ____

Are you happy for Dr Anthony Crombie to call your next of kin after any operations? Yes/No
Next of kin name: ______________________________ Relationship to you: ________________________
Contact number/s: __________________________________ / __________________________________

DR ANTHONY CROMBIE
ORAL AND MAXILLOFACIAL SURGERY

MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

To ensure optimal medical and surgical care, it is very important that you answer the following questions thoroughly and honestly please.

Are you being treated by a Doctor at present? Yes / No____

Are you taking any tablets or medicines at present? Yes / No ________________________________

List:____

Have you been a hospital patient in the past 2 years? Yes / No ______________________________

Do you normally require antibiotic cover before dental treatment? Yes / No____________________

Are you allergic to any medications? Yes / No ____

Have you ever had? Please tick:

❑ Kidney Disease	❑ Tuberculosis	❑ Do you smoke?	❑ Epilepsy
❑ Excessive Bleeding	❑ Hepatitis	❑ Asthma	❑ Diabetes
❑ Heart Complaint	❑ Heart Valve Disorder	❑ Cardiac Pacemaker	❑ Anaemia
❑ Thyroid Disease	❑ High Blood Pressure	❑ Nervous condition	❑ Stroke

❑ Contact with HIV/AIDS ❑ Other ____

Ladies, are you pregnant? Yes / No If Yes, due when? ______________________________________

Have you had any previous problems with Dental treatment? ______________________________

❑ I have confidential medical information that I do not wish to write down. I would prefer to speak to the Surgeon

I have completed these forms to the best of my knowledge and acknowledge that this represents an accurate medical history. On future visits, I will advise the surgeon of any changes to this history.

Signed____ Date_____/_______/_________

(To be signed by parent/guardian if patient under 18)

DR ANTHONY CROMBIE
ORAL AND MAXILLOFACIAL SURGERY

NO PHOTOGRAPHS, VIDEO OR RECORDING POLICY

It is the policy of Dr Anthony Crombie, Oral and Maxillofacial Surgery to not allow any photographs, video or recording of any procedures in this practice.

PATIENT SIGNATURE: ____ Date: ____ /____ /____ *(to be signed by parent/guardian if patient is under 18 years of age)*

PRIVACY

The information requested above and relevant health information may be sent to other health professionals (eg. your anaesthetist) or organisations (eg. hospitals, pathology collection centres) where this is needed to provide your health care. As required by the Commonwealth Privacy Act 1988 we request your consent to sending this information to these practitioners and organisations. Information will only be sent for the purpose of providing your health care. You may request to review the information we have on file about you for the purposes of checking that the information is correct.

I consent to Dr Anthony Crombie sending my personal and health information to other persons or organisations where this is necessary to provide my health care.

PATIENT SIGNATURE: ____ Date: ____ /____ /____ *(to be signed by parent/guardian if patient is under 18 years of age)*

CLINICAL PHOTOGRAPHY CONSENT

Occasionally, clinical photography will be taken to assist in your care. These become part of your confidential medical records. We also would like to ask you for permission to use these photos for educational purposes in addition to their use as part of your medical care. All images used for purposes other than the medical records are de-identified; except in facial surgery cases where specific written permission must be given for identifiable images to be used. Names are not used and as far as possible, identifying factors are masked.

These photos are extremely helpful in teaching other doctors and helping other patients make an informed decision about their surgery. Do you consent to your de-identified before and after clinical photos being used:

- For the purpose of teaching other health professionals such as doctors, nurses and associated students? Yes / No
- In publications eg articles in medical journals? Yes / No
- To educate other patients? Yes / No

These photos will not be sold or transferred to any other entity for purposes that have not been agreed to.

Declaration: I grant permission for photographs of me to be used in the formats indicated above. I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

PATIENT/CARER SIGNATURE: _______________________________________ Date: ____ /____ /____ *(to be signed by parent/guardian if patient is under 18 years of age)*