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**PATIENT INFORMATION / MEDICAL HISTORY**

**MEDICAL HISTORY**

**Current regular medications** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current medical conditions** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Height** \_\_\_\_\_**cm** **Approximate weight** \_\_\_\_**kgs**

**Do you take any blood thinners / Aspirin regularly?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take any medication for your bones?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had radiotherapy / chemo treatment to your jaw bones?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ladies are you pregnant? If so, how far along?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke or vape? Yes / No Frequency** \_\_\_\_\_\_\_\_\_\_**per day** **Have you quit, when?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any joint replacements?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of replacement** \_\_\_/\_\_\_/\_\_\_

**MEDICARE NO** |\_\_ |\_\_ |\_\_ |\_\_ |\_\_ |\_\_\_|\_\_ |\_\_\_|\_\_\_| |\_\_| Reference: |\_\_| Expiry: \_\_\_\_/\_\_\_\_

*Are your bank account details registered with Medicare?* **Please circle** Yes / No

**PRIVATE HEALTH FUND**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Membership No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE** Hospital Cover / Extras Cover / Unsure

**Dept. Veterans’ Affairs No** |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| **DVA Card Colour**: \_\_\_\_\_\_\_\_\_ Exp: \_\_\_/\_\_\_

**Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title** Dr / Mr. / Mrs / Ms. / Miss / Master **Sex: M / F D.O.B: \_\_\_\_\_\_\_/ \_\_\_\_\_\_\_ / \_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Number (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address (for correspondence only) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Next of Kin (emergency contact) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***ACKNOWLEDGEMENT OF FEES / PAYMENT***

***All consultation fees are to be paid on the day of consultation (by either Eftpos, Visa or Mastercard). All surgical fees are to be paid 1 week prior to surgery to avoid your procedure being cancelled. The above information is correct to the best of my knowledge, and I understand the conditions of payment.***

**SIGNATURE OF PATIENT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_ / \_\_\_\_ /2024

**NAME OF PARENT / GUARDIAN (if child is under 18 years old \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***PLEASE TURN THIS PAGE OVER***

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**CONSENT TO COLLECT PATIENT INFORMATION**

**Due to the recent changes in the Privacy Laws, a person’s written consent is now required for a health professional to obtain medical information about them and to be able to communicate that medical information about them to another medical practitioner.**

**Due to these changes, the following form will need to be signed if you are happy for Dr Shannon Webber to obtain such information and to liaise with other health practitioners concerning your condition.**

**I give permission for Dr Shannon Webber to:**

1. Obtain medical information about me from other medical practitioners, including consultation notes and results of tests or investigations performed by other medical practitioners that pertain to my medical condition.
2. Communicate with other health professionals directly involved with my medical condition.

1. Communicate with the referring medical practitioner concerning my medical condition.
2. I consent to the taking of photographs and x-rays before, during and after treatment and to the use of same by the doctor in advertising, scientific papers, or demonstrations.
3. Use email as a form of correspondence (as per email on previous page).
4. Use SMS as a form of correspondence.

**I (name)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_

**Street Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suburb:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Postcode:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_**

**Name of parent / guardian: (if patient is under 18 years old)** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**