Mr JOSEPH GUNN
Oral & Maxillofacial Surgeon

PATIENT REGISTRATION AND MEDICAL HISTORY

Mr /Mrs /Miss /Ms /Mst /Dr Last Name _____ *First Name* _____

*Postal Address*_____

_____*Postcode:*_____

*Date of Birth: day*_____ *month*_____ *year*_____ *Age*_____

*Telephone: AH*_____ *Mobile*_____

Occupation of Patient: _____ *Name of Dentist/Doctor referring:* _____

*Name and Address of Person Responsible for Fees*_____

Emergency Contact _____ *Ph/mobile no:* _____

*Email Address: .*_____

Hospital Insurance: □ YES □ NO *Dental Extra's:* □ YES □ NO

Name of Health Fund _____ *Membership No. / Ref.* _____

Medicare No: _____ *Reference No: (No. next to your name)* _____

Have you ever had any of the following: (if yes please tick the box)

□ *Heart Problems*	□ *High Blood Pressure*	□ *Rheumatic Fever*
□ *Stroke*	□ *Asthma*	□ *Chest or Breathing Problems*
□ *Diabetes*	□ *Kidney Disease*	□ *Stomach Ulcer or Bowel Problems*
□ *Bleeding Problems*	□ *General Anaesthetics*	□ *Fits or Epilepsy*
□ *Anaemia*	□ *Complication with Anaesthetics*	□ *Hepatitis A, B or C (please circle)*
□ *Osteoporosis/Bone Disorders*		

Do you take any Medications: □ YES □ NO *(if yes please name)*_____

Are you Allergic to any Drugs, Foods or Substances: □ YES □ NO _____

Do you: Smoke Cigarettes □ YES □ NO □ OCCASIONALLY

Use Recreational Drugs □ YES □ NO □ OCCASIONALLY

Females: Are you Pregnant □ YES □ NO □ POSSIBLY

Do you consider yourself to be in one of the risk groups for HIV / AIDS / HEPATITIS? Confidentiality of discussion is assured. Your treatment will not be affected as universal precautions are used in this practice.

□ YES □ NO □ POSSIBLY

Patient / Guardians Signature _____ *DATE:* _____/_____/ *20*_____

Thank you for completing these questions