Dr. Norman Stanton
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Patient Information

Dr/Mr/Mrs/Miss/Ms/Mstr First Name:________________________ Surname:________________________

Address:____

Email:____

Phone:____________________ Mobile:____________________________ DOB: _____ /_____ /______

Occupation:______________________________ Referred by:________________________________

Regular Dentist:______________________________ Suburb:________________________________

Regular Doctor:______________________________ Suburb:________________________________

Medicare # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref # ____ Expiry: __ __ / __ __ __ __

Do you have private health insurance? Yes ☐ No ☐

Name of fund:______________________________ Membership #__________________________

Private hospital cover: Yes ☐ No ☐ Dental Cover: Yes ☐ No ☐

VET Affairs #__________________________________ White ☐ Gold ☐

I give permission to be contacted by email, phone or text using the details above? Yes ☐ No ☐

Person responsible for account (self/parent's name):________________________________

For Medicare claims purposes, if a parent is responsible for the account, please provide the following information.

DOB: _____ /_____ /_____ Phone or Mobile:____

Medicare # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref # ____ Expiry: ___ ___ / ___ ___ ___

Emergency Contact Name:____

Relation:____________________________ Phone:__________________________

PLEASE SEE NEXT PAGE

Medical History

Please tick the box of any conditions you have from the following list:

☐ Asthma	☐ Excessive Bleeding	☐ Osteoporosis
☐ Blood Pressure High/Low	☐ Heart Conditions	☐ Pregnant
☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever
☐ Epilepsy	☐ Kidney Problems	☐ Smoker

Other: ____

Have you had any operations? Yes ☐ No ☐

Please list: ____

Do you have any allergies? Yes ☐ No ☐

Please list: ____

Hepatitis and other viruses are of increasing concern in health care.
Could you be in the high-risk category of viral infection? Yes ☐ No ☐

Are you taking any medications?
This includes oral contraceptive pill, asthma preparations, blood thinners, drugs for pain, arthritis, osteoporosis, anti-depressants, vitamins, herbal or Chinese supplements. Yes ☐ No ☐

Please list: ____

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Consent to Collect Patient Information

OMF Clinic 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 for optimum assessment, diagnosis, treatment and to be proactive in your health care needs.

We will use the information you provide for administrative purposes in running our medical practice and billing purposes (including Medicare and health insurance commission requirements). Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice will be as 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 may 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.

Patient Signature: ________________________________ Date: __ __ / __ __ / __ __ __ __