TASMANIAN
ORAL • MAXILLOFACIAL • IMPLANT
SURGERY

DR ANKIT GARG
MBBS BDS Post Grad Dip OMFS FRACDS (OMS)
ORAL AND MAXILLOFACIAL SURGEON

Title_____Given Names_____Surname_____

Preferred name_____Date of birth_____/_____/_____Marital status_____

Country of birth_____Preferred language_____Your occupation_____

Home address_____State_____

Home number_____Mobile_____Email_____@_____

Emergency contact person_____Phone Number_____

Referring Doctor_____Family Dr_____

Medicare number_____Ref No_____Expiry date_____

Private Health Fund_____Member No_____

DO YOU HAVE HOSPITAL COVER _____Hospital cover for over 12 mths Y or N

Overseas fund name _____Overseas Member No_____Date Joined_____

Pension card or Health care number_____Expiry date _____

DVA Number_____Colour of card_____Expiry date_____

Worker compensations claim Yes or No – If yes please see Practice Manager

Allergies to medications or any bad reactions (E.g. Endone, Morphine, latex tapes)

_____

_____

Do you take any blood thinner medications Yes No
Please list medication below

_____

Pradaxa, Xarelto Warfarin Heparin / Other_____

Do you take any Diabetes medications and insulin therapy Yes No
Please list medication below

_____

Medical care requires full knowledge of patient health information by all member of the medical team. To ensure quality and continuity of patient care, patient's health information must be shared with other healthcare providers/diagnostic facilities from time to time. Some information about patients is provided to Medicare and Private Health Fund, if relevant, for legal and medical rebate reasons. If you have any concerns, please ask to speak to the Practice Manager

Please turn over

MEDICAL HISTORY & CURRENT CONDITIONS

Have you ever had any of the following conditions? Please circle all

Rheumatic Fever	Yes / No	Diabetes	Yes / No
Heart Condition	Yes / No	High Blood Pressure	Yes / No
Chest Complaints	Yes / No	Kidney Disease	Yes / No
Asthma	Yes / No	Liver Disease	Yes / No
Bone Disease	Yes / No	Bleeding Disorders	Yes / No
Epilepsy	Yes / No	Blood Transfusions	Yes / No
Arthritis	Yes / No	Hepatitis	Yes / No
HIV /AID	Yes / No	Radiotherapy	Yes / No
Reflux	Yes / No	Drug Addiction	Yes / No
Ulcer	Yes / No	Depression	Yes / No
Hernia	Yes / No	Anxiety	Yes / No

If you are a female are you pregnant Yes / No

Do you have any other medical condition not already mentioned? Please list

_____

_____

Are you taking any medications (Eg tablets /mixtures/injections/puffers) Please list?

_____

_____

In the last 5 years had you had any major operations

_____

Do you drink alcohol Yes / No Amount per day _____

Do you smoke Yes / No Amount per day _____

What is your approximate weight_____Height_____

Patient or Parent / Guardian Signature_____Date_____