Dr Dylan M. Hyam
ORAL AND MAXILLOFACIAL SURGEON
M.B., B.S. (Hons), B.D.S. (Hons), FRACDS (OMS)

Suite 9
Australian Surgeons Building
13 Napier Close
Deakin 2600 ACT
Ph: 02 6282 3848

SURGERY OF THE FACE, JAWS, MOUTH, AND TEETH

NEW PATIENT REGISTRATION FORM

Title: ____ First Name: ______________________ Last Name: ______________________

Street Address: ______________________ Suburb: ______________

State: ______________ Postcode: __________ Date of Birth: ____/____/____

Mailing Address: (if different from above) ______________________

Home Phone: ______________ Work: ______________ Mobile: ______________

Medicare Number: ______________ Valid to: ______________ Reference No: ______________

Health Fund Name: ______________ Membership No: ______________

Health Care Card Number: (if applicable) ______________________

Veterans Affairs Card Number: ______________ Type: Gold/White

Is your visit in relation to Worker's Compensation or Third Party Claim: Yes / No

If yes, please provide details: ______________________

EMERGENCY CONTACT DETAILS

Title: ____ First Name: ______________ Last Name: ______________________

Relationship to Patient: ______________________

Address: (if different) ______________________ Suburb: ______________

State: ______________ Postcode: ______________

Home Phone: ______________ Work ______________ Mobile: ______________

MEDICAL HISTORY DETAILS

Referring Practitioner: ______________________

General Practitioner: ______________________

Previous Surgeries: ______________________

Previous Medical Conditions: ______________________

Allergies: ______________________

Have you ever been prescribed a bisphosphonate medication: Yes / No /Not Sure

Current Medications: ______________________

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Do you, or have you ever, smoked cigarettes: Yes / No

What is your average daily alcohol consumption: __________ Glasses / day

Do you have any current treating specialists: Yes / No Names: ______________

Do you currently, or have you ever, had any of the following:

□ Rheumatic Fever / Endocarditis	□ Asthma / Pneumonia	□ Epilepsy / Encephalitis
□ Heart Attack	□ Kidney Problems	□ Bleeding problems
□ Heart Valve Surgery	□ Liver Problems	□ Prosthetic Joint Surgery
□ Stroke / Mini Strokes	□ Intestinal Disease	□ Radiotherapy
□ Angina	□ Cancer	□ Chemotherapy