PATIENT INFORMATION

Mr/Mrs/Ms/Miss/Mst/Dr (please circle)

Given Names:_____Surname:_____Date of Birth:_____

Address:_____ Suburb:_____Post Code:_____

Phone: (Home)_____(Mobile)_____Email:_____

Medicare No:_____Ref No:_____ Expiry Date:_____/_____

Private Health:_____Membership No:_____ Hospital Cover?_____Extras Cover?_____

Department of Veterans Affairs No:_____ Colour (Gold/White/Orange):_____

Pension/Health Care Card No:_____ Expiry Date:_____/_____

Referring Doctor:_____Suburb:_____

General Practitioner:_____Suburb:_____

Emergency Contact (Name):_____Relationship:_____Contact No:_____

Allergies:_____

Current Medications:_____

Any medical conditions eg: Asthma, Diabetes, Heart Condition:_____

_____ **Height:_____ Weight:_____**

Are you vaccinated against Covid-19 (please circle)? Y / N

To be completed by parent or guardian if patient is still on parent/guardian's Medicare card

Name of person responsible for account:_____ DOB:_____/_____/_____

Medicare No: _____Ref No:_____ Expiry Date:_____/_____

If different from above, please provide an email address for the surgery invoice to be sent:_____

Is this a Workcover Claim? Y/N:_____ If yes, Name of Employer:_____

Contact person at your Employer:_____Contact No:_____ Claim No:_____

Address of Employer:_____

FEES: Fees are due and payable at the time of consultation.
Please note this practice does not bulk bill without prior arrangement with the Doctor (DVA patients excluded).

I have read, understood and agree to comply with the above-mentioned conditions. I acknowledge that Queensland Maxillofacial Group and its agents are indemnified for all loss and damage including debt collection costs.

Signature:_____Date: _____

Queensland Maxillofacial Group
Specialist Mouth, Jaw & Face Surgery

Suite 1/8 Vine Street
Stones Corner QLD 4120
P: 07 3063 7666
info@maxfac.com.au
www.maxfac.com.au

Medical Record Authority

I, _____ authorise the release of all documents and information comprising my medical records including but not limited to clinical notes, comments, photographs, diagrams, x-rays and reports in your possession to Queensland Maxillofacial Group of Suite 1 / 8 Vine Street, Stones Corner. I further authorise Queensland Maxillofacial Group to contact any and all of my medical providers to discuss my medical records and care.

_____ _____

Signed Date

Medical Record Authority
(Under 18)

I, _____, parent/guardian of _____ (the child) authorise the release of all documents and information comprising the child's medical records including but not limited to clinical notes, comments, photographs, diagrams, x-rays and reports in your possession to Queensland Maxillofacial Group of Suite 1 / 8 Vine Street, Stones Corner. I further authorise Queensland Maxillofacial Group to contact any and all of the child's medical providers to discuss the child's medical records and care.

_____ _____

Signed Date