JASON ERASMUS
Oral & Maxillofacial Surgeon

Patient Registration Form

PERSONAL INFORMATION

First Name		Title	
Surname		Date of Birth	
Profession			

Home Address		**Postal Address (if different)**	
Address line1		Address line1	
Address line2		Address line2	
City		City	
Postal code		Postal code	

Work Address	
Company name	
Address line1	
Address line2	
City	
Postal code	

Telephone Numbers			
Home		Work	
Cell phone			

Email Address	

Referring Doctor			
Dentist		Medical GP	
Dentist's address		GP's address	

Next of Kin			
Name		Tel number	

Medical Insurance			
Medical insurance?	Y / N		
Name of company		Membership no	
Person responsible for account		Telephone number	
Receiving a benefit?	Y / N	Type of benefit	
ACC claim?	Y / N	ACC claim number	

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MEDICAL QUESTIONNAIRE

	Please tick the box ONLY IF POSITIVE		
Diabetes mellitus	☐	If yes, for how long?	
		Medication:	
		Any complications?	
Epilepsy	☐	Last convulsion:	
		Medication:	
Drug allergies	☐	1. 2. 3.	
Allergy to Latex	☐		
Allergy to heavy metals	☐		
Bleeding tendency	☐		
Family history of bleeding problems	☐		
Previous blood clots / DVT/ Pulmonary embolus	☐		
Bruise easily (requiring you to see a doctor?)	☐		
Hypertension	☐		
Previous heart attack	☐	When?	
		Bypass surgery or stent placed?	
		Medication:	
		Cardiologist:	
		Last seen cardiologist:	
Angina	☐	When?	
Heart failure or "fluid on the lungs"	☐		
Heart valve problems	☐	Type:	
Cardiac pacemaker or defibrillator	☐		
Previous stroke or mini-stroke	☐	When?	
Rheumatic fever	☐	When:	
		On antibiotics for it:	
Rheumatoid arthritis	☐		
Any damage to your neck or back	☐		
Pregnant or possibly pregnant	☐	How far:	
Previous jaundice	☐		
Porphyria	☐		
Asthma	☐	Last attack:	
		Hospital admissions?	
		Inhalers used:	
Kidney problems	☐	Type:	
Emphysema or chronic bronchitis		Hospital admissions?	
Snore or stop breathing when you sleep	☐		
Tuberculosis	☐		
Thyroid problems	☐	Dosage:	
Currently on warfarin, aspirin or other blood thinning medication Cortisone therapy	☐	Reason for taking:	
		Dosage used:	
		Last taken:	
Other medication currently taking	☐	**Drug**	**Dosage (mg)**
		1.	
		2.	
		3.	
		4.	
		5.	

		6.	
		7.	
		8.	
Other conditions	☐	1. 2.	
Hospital admissions past 2 years	☐	Reasons: 1. 2. 3.	
Previous major operations	☐	1. 2. 3. 4.	
Have you ever had a serious or life threatening reaction to general anesthesia?	☐		
History of anaesthetic problems in a family member?	☐		
Smoke	☐	How many per day?	
Chronic sinusitis	☐		
HIV/AIDS	☐		
Hepatitis B or C positive	☐		

Do you have any specific cultural/spiritual/religious needs that we should be aware of?