

NEW PATIENT FORM

To assist us with patient records, please fill in the following questionnaire:

Contact Details

Patient name:

Address:

Suburb: **Postcode:**

Telephone: Home: Work:

Mobile: Email:

Date of birth: / / **Age:**

Occupation:

Next of kin:

Phone: Mobile:

Name of your referring Doctor:

Contact details:

Name of your Physiotherapist:

Contact details:

Name of your Podiatrist:

Contact details:

Private Health Insurance Fund:

Member number:

Medicare card number: ____ ____ ____ ____ ____ ____ ____ ____ ____ REF No: Valid to: /

Pension Card/ Health Care Card Number:

Veterans Affairs Care Card Number: Gold Card: YES / NO

A referral (within 12 months) from your Doctor is required for your Medicare refund.

Privacy:

I, (print name):

Of (address):

Consent to Park Clinic Orthopaedics collecting, holding, using and disclosing my personal information (including health information and other sensitive information) as set out in their collection statement.

Patient Signature:

Date: / /

Please refer to the attached information sheet for consultation fees

I hereby agree to pay all associated fees relating to my consultation/s and/or surgery, performed by Mr Blackney.

I acknowledge that if an account is overdue, Mr Blackney reserves the right to refer the account to a collection agency.

I agree to meet all reasonable costs and commissions incurred in employing the said agency, to collect the overdue account.

I have read and understood this fee arrangement.

Patient Signature:

Date: / /

Health Questionnaire:

Please read the following and tick if it is applicable to you:

Are you diabetic? Yes No

Are you a smoker? Yes No If Yes, how many per day?

If Yes, are you aware that smoking has serious adverse effects on skin and bone healing? Yes No

Are you on the following drugs?

Warfin Yes No

Asprin Yes No

Iscover Yes No

Clopidogrel Yes No

Insulin Yes No

Methotrexate Yes No

Prednisolone Yes No

Xarelto Yes No

Do you have any allergies? Yes No

If so, please list:

Have you had any problems with a previous anaesthetic? Yes No

If so, please describe:

Have you had any of the following in the last 12 months:

Acute Myocardial Infarct (heart attack)? Yes No

Had a Stent or Pace maker inserted? Yes No

Have you ever had a Deep Vein Thrombosis / Pulmonary Embolism? Yes No

Do you live alone? Yes No

If **No**, with? Husband Wife Partner Parents Friend

If **Yes**, do you have someone close to you that can help you recuperate? Yes No

Do you have stairs at home? Yes No

At work are you mainly? Seated Standing Walking 50/50

Can you modify work for a time after surgery? Yes No

Do you realise that excess weight significantly increases your risk of complications? Yes No