

# Patient Registration Form



Title Dr / Mr / Mrs / Miss / Ms / Other.....

Name .....

Surname .....

Date of birth ..... Age .....

Gender Male Female

Address .....

.....

.....

Phone Home .....

Work .....

Mobile.....

Email .....

Occupation .....

Next of kin .....

Relationship to patient.....

Contact number.....

Medicare number.....

Pension card number .....

Reference number next to your name .....

Health card number.....

## If patient is underage

Parent/Guardian Name .....

Medicare number ..... Reference number next to your name .....

Name of referring Doctor .....

Address .....

Name of Usual GP .....

Address .....

Name of referring Physiotherapist / Podiatrist .....

Address .....

## Medical history

Please circle

Do you smoke? Yes No

If yes how many do you smoke a day.....

Do you have diabetes? Yes No

If yes, what medications do you take?  
.....

Have you had a blood clot to the legs or lungs? Yes No

Are you on blood thinners? Yes No If yes which one .....

Do you have an autoimmune condition? Yes No

If yes, what medication do you take?  
.....

Do you have heart disease or an arrhythmia? Yes No

Do you have a pacemaker? Yes No

Have you had previous anaesthetic problems? Yes No

Do you have any other relevant health conditions?  
.....  
.....

**Recovery from surgery**

**Please circle**

Do you live alone? Yes No

If yes, do you have someone to help you recuperate during the first 2 weeks following surgery. Yes No

Do you have stairs at home? Yes No

Does your work involve? Sitting Standing Walking Heavy labour

**Private Health Fund**

Fund name .....

Veteran Affairs card number .....

Membership number..... Member for more than 12 months Yes No

**Work Cover / Transport Accident Commission Claim Details**

Date of injury..... Employer address .....

Claim number.....

Insurance company.....

Insurance contact name.....

Employer contact name.....

Employer..... Employer phone number.....

**Privacy Statement**

Mr Hamish Curry respects your right to privacy and complies with the legislation relating to the collection, storage, use and disclosure of health information. Our comprehensive privacy policy is available on request.

<b>Fees</b>	Initial Consultation	Standard Fee	\$220
	Second Opinion Consultation/ Complex Consultation	Standard Fee	\$250
	Review Consultation	Standard Fee	\$110

The policy of this practice is **payment on the day of consultation**. If payment presents a problem, please speak with the secretary before the consultation.

**How did you hear about us?**

**Please circle**

GP recommendation Yes

Hospital Website Yes

Friends or family Yes

Google search Yes

Other .....

**By signing this form, I have had opportunity to review the privacy policy. I understand and accept the above privacy statement and billing procedures.**

Signature .....

Date .....