# NEW PATIENT REGISTRATION FORM

⁜ This form ensures your privacy as personal details will not be asked in the presence of others. Some parts of the form may not relate to you e.g. Veterans affairs, Workers Compensation etc. Once your details are entered into your secure file this document will be destroyed.

Title: ........................ Given Name: ........................ Surname: ........................

Date of Birth: ........................ Email Address: ........................

Home Phone: ........................ Mobile Phone: ........................

Postal Address: ........................

Suburb: ........................ Postcode ........................

Usual GP and Practice: ........................

Medicare Card No: _ _ _ _ _ _ _ _ _ _ _ _ (no. beside your name) Expiry: ........................

Do you have Private Health Insurance (please circle): YES / NO

Name of Fund: ........................ Membership No: ........................

Aged Pensioner Card No: ........................ Expiry: ........................

Veterans Affairs Card No: ........................ Expiry: ........................

Next of Kin: ........................ Contact: ........................

Work Cover Claim Number and Case Manager: ........................

Employer Name and Contact Numner: ........................

As a health care provider in the private sector, the Complete Orthopaedic Clinic is bound by the National Privacy Principles provided in the Privacy Act 1988. These govern how we collect, handle, use, distribute and store personal information collected from our patients at the clinic. Ordinarily we do not release the contents of your file without consent. However, there may be occasions when the law requires us to disclose certain information without your consent. When dealing with other health care professionals, in order to obtain accurate diagnosis or treatment options we will ask your full consent to disclose personal medical details. Please indicate below and sign your consent for details to be disclosed when necessary.

☐ I DO ☐ I DO NOT

Give permission for details relating directly to my medical condition to be discussed, if necessary, with other health care professionals.

Patient Name: ........................ Signature: ........................

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## HEALTH QUESTIONNAIRE:

Information supplied here is to help us look after you, manage your risks and optimise your treatment.

Are you diabetic? ☐ YES ☐ NO

If yes, what type? ☐ DIET ☐ TABLETS ☐ INSULIN

Are you a smoker ☐ NO ☐ YES - per day .................. cigarettes

SMOKING AND POORLY CONTROLLED DIABETES BOTH HAVE SERIOUS ADVERSE EFFECTS ON SKIN AND BONE HEALING, AND INCREASE YOUR RISK OF INFECTION.

Do you take any of the following medications (tick if applicable):

☐ WARFARIN ☐ ASPRIN ☐ ISCOVER ☐ PRADAXA

☐ PLAVIX ☐ METHOTREXATE ☐ ENDONE ☐ OXYCODONE

☐ PAIN PATCHES ☐ PREDNISOLONE ☐ ANTI-INFLAMMATORIES

Please list all the tablets you take and dosages (or supply list) : ..............................................................................

..............................................................................

..............................................................................

Please list any allergies you have: ..............................................................................

Do you have any of the following:

| | | |
|---|---|---|
| Severe Anaesthetic Reactions | ☐ YES | ☐ NO |
| Cardiac Stents | ☐ YES | ☐ NO |
| Pacemaker | ☐ YES | ☐ NO |
| History of Blood Clots (DVT/PE) | ☐ YES | ☐ NO |
| Blood Vessel Disease | ☐ YES | ☐ NO |
| Depression | ☐ YES | ☐ NO |

Do you have someone to care for you while you recover from surgery? ☐ YES ☐ NO

Can you arrange time off work and alternative work duties if required? ☐ YES ☐ NO

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