PERSONAL INFORMATION

This information is needed at <u>your consultation</u> and can be obtained in advance from your health fund

Title ……. First Name …… Surname …… Preferred name …….

D.O.B …… Occupation ……

Residential Address ……..

……

Mobile ……Home ……..

For your privacy, please circle any numbers NOT to be used for messages

Can we leave messages for you identifying the practice as the caller? Yes ☐ No ☐

Email ……..

By providing my email above, I consent to use email and acknowledge that email is not a secure form of communication

Emergency contact: ……

Relationship …… Phone …….

If patient under 18 years, person responsible for account:

Name …… Phone ……..

Address ……..

……..

Are there any custody agreements or court orders in place? Yes ☐ No ☐

Details……..

Who referred you to this practice (Doctor or Dentist)

Name …….. Referral Date ……

Address ……

Phone ……..

Who is your other Practitioner (medical or dental)

Dr …….. Phone ……..

Practice Name & Address ……..

Information disclosure

I authorise the following person to take messages regarding a reminder/change of appointment/clinical details relating to my healthcare (if you do not nominate someone below, we will only be able to speak with you regarding the above)

Name ……

Relationship ……

Phone number ……..

Medicare Number ……..

Expiry Date …….. Reference Number ……

DVA number …… Reference Number ……

Expiry Date……Card Type: White ☐ Gold ☐

Work cover claim number ……..

Do you have private health insurance? Yes ☐ No ☐

Name of health fund ……

Membership number ……..

Approximate date joined ……

Does your insurance cover <u>hospital</u>? Yes ☐ No ☐

Does your insurance cover <u>dental</u>? Yes ☐ No ☐

Are there any excesses, restrictions, or exclusions on this policy? Yes ☐ No ☐ *(Please list)*

1. *Please <u>CIRCLE</u> if you have an assigned POWER OF ATTORNEY or have an ADVANCED HEALTH DIRECTIVE*

2. *Please read the following and <u>TICK</u> the boxes to confirm you understand:*

   ☐ *I accept responsibility for the information provided above, for agreement to the treatment plan.*

   ☐ *I accept responsibility for payment of all accounts. Payments for consultations are required on the day. Unless otherwise arranged, payments for surgery in hospital are to be made within 10 days and claims to Medicare and/or health Funds are to be submitted after payment is receipted.*

   ☐ *I understand that payments not made on time may be subject to collection charges.*

Patient Name…….

MEDICAL INFORMATION AND HISTORY

To fully optimise your care, we require your complete medical history.

Have you had/do you have ANY medical conditions? Yes ☐ No ☐

For example, diabetes, heart problems, thyroid issues, epilepsy, asthma, obstructive sleep apnoea, (OSA), osteoporosis etc.

Type of Illness	***Approx Date of Onset***	***Still current?***	***Treating Doctor***

Please list *Have you ever had an operation?* Yes ☐ No ☐

Operation	***Approximate Date***	***Any Complications?***	***Treating Doctor***

Are you taking ANY medications? Yes ☐ No ☐

Including any antibiotics, pain killers including Nurofen, injections, aspirin, other blood thinners, osteoporosis medication or vitamins/ herbal supplements

Medication Name	***Strength***	***TIME of day taken***

Height: cm	***Weight: kg***

Do you want your details to be sent to My Health Record?	Yes ☐ No☐
Are you fully vaccinated for COVID?	Yes ☐ No ☐
Have you had COVID before? If so, what was your date of diagnosis? _____	Yes ☐ No ☐
Have you had radiation or chemotherapy?	Yes ☐ No ☐
Do you smoke/vape or have previously smoked/vaped? If so how many/often _____	Yes ☐ No ☐
Do you have any respiratory conditions, for example: asthma, emphysema, obstructive sleep apnoea? If so, do you require steroids, home oxygen, or CPAP?	Yes ☐ No ☐
Have you EVER had a general anaesthetic?	Yes ☐ No ☐
Have you or your relatives had ANY difficulty with a general anaesthetic? If yes, please give details	Yes ☐ No ☐
Are you under treatment for psychological problems?	Yes ☐ No ☐
For women, could you be pregnant?	Yes ☐ No ☐
Do you have risk factors for Creutzfeldt-Jakob Disease (CJD) or related diseases? For example: (please circle) Pituitary Hormone (for growth or fertility)? Neurosurgery before 1988? Corneal grafts? Family history of CJD?	Yes ☐ No ☐
Do you have any allergies to food or medications? If yes, please give details and reaction details	Yes ☐ No ☐

Allergy	*Details of Reaction*

Patient Name…….

Thank you for supplying this information. It will help us treat you as safely and efficiently as possible. It is necessary for us to collect andpass on information from patients and sometimes others associated with your care in order to attend to your health needs, and for associated administrative purposes. You have access to any personal information of yours that we hold, and the right to know how that information is used. Please ask us if you would a copy of our Privacy Policy or if you have any concerns regarding this process.

Signature (patient/person responsible): ……..

Name: ……..

Date: _ _/__ /____