



PERSONAL INFORMATION

Title First Name Surname Preferred name	
D.O.B Occupation Residential Address Mobile Home <i>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 <input type="checkbox"/> No <input type="checkbox"/></i> Email <i>By providing my email above, I consent to use email and acknowledge that email is not a secure form of communication</i>	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 <input type="checkbox"/> No <input type="checkbox"/> 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>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)</i> Name Relationship Phone number
Medicare Number Expiry Date Reference Number DVA number Reference Number Expiry Date Card Type: White <input type="checkbox"/> Gold <input type="checkbox"/> Work cover claim number	Do you have private health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of health fund Membership number Does your insurance cover <u>hospital</u> ? Yes <input type="checkbox"/> No <input type="checkbox"/> Does your insurance cover <u>dental</u> ? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you held this level of cover for 12 months or more? Yes <input type="checkbox"/> No <input type="checkbox"/> Are there any excesses, restrictions, or exclusions on this policy? Yes <input type="checkbox"/> No <input type="checkbox"/> (Please list)

1. Please CIRCLE if you have an assigned POWER OF ATTORNEY or have an ADVANCED HEALTH DIRECTIVE

2. Please read the following and TICK 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. Prepayment for surgery is to be made at least 7 days prior. Claims to Medicare and/or health Funds are to be submitted after payment is received.

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

De-identified medical records (including photographs) are used by this practice for purposes of education, patient management, and research. Please advise the staff if you do not agree to this.

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 antibiotics, pain killers (eg any brands of ibuprofen or aspirin or other anti-inflammatory) blood thinners, vitamins, herbal or food supplements, bone strengthening or weight loss/diabetic medications, **including injectables** and weekly, monthly, 6monthly and yearly treatments*

Medication Name	Strength	TIME of day taken

Height: _____ cm	Weight: _____ kg
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Do you give consent to your doctor to access your My Health Record if needed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you fully vaccinated for COVID?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had COVID before? If so, what was your date of diagnosis? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had radiation or chemotherapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you accept the risk of a blood transfusion in the unlikely event it is unavoidable?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you smoke/vape or have previously smoked/vaped? If so how many/often _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any respiratory conditions, for example: asthma, emphysema, obstructive sleep apnoea? If so, do you require steroids, home oxygen, or CPAP?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you EVER had a general anaesthetic?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you or your relatives had ANY difficulty with a general anaesthetic? If yes, please give details		Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you under treatment for psychological problems?		Yes <input type="checkbox"/> No <input type="checkbox"/>
For women, could you be pregnant?		Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
Do you have any allergies to food or medications? If yes, please give details and reaction details		Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergy	Details of Reaction	

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 and pass on information from patients and sometimes others associated with your care in order to attend to your health needs, and for associated administrative purposes and education. 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 like a copy of our Privacy Policy or if you have any concerns regarding this process.

Notice: Please be advised that for your safety, CCTV surveillance is in use throughout our practice. Recordings are for security purposes only and handled in compliance with privacy laws.

Signature (patient/person responsible):.....Name:Date.....