

PERSONAL DETAILS

NEW PATIENT FORM (Side 1)

Mr Mrs Master Miss Ms Dr Prof Other

Date of Birth: ____/____/____

■ Surname: _____ Given Name: _____

Address: _____

Suburb: _____ Postcode: _____

Email: _____

Occupation: _____

■ Telephone Numbers: Home: _____

Work: _____ Mobile: _____ Emergency: _____

■ Next of kin details (family member or friend / medical power of attorney)

Name: _____ Relationship to you: _____

Contact number: _____

YOUR GP's DETAILS

■ GP's Name: _____ GP Provider Number: _____

Practice details: _____

Contact number: _____

CLAIM DETAILS

■ Medicare Number: _____ Ref No: _____ Exp Date: _____

■ Private Health Insurance: Yes No Fund Name: _____ Fund Number: _____

■ Concession Cards:

Aged or Disability Pension No: _____ Exp Date: _____

Dept. Veterans Affairs Card No: _____ White Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

■ WorkCover Details (If applicable) Is this visit related to a WorkCover injury Yes No

Claim No: _____ Date of Injury: _____

Insurer: _____ Employer: _____

Claims Officer Details

Name: _____ Phone: _____ Fax: _____

■ TAC Details (If applicable): Date of Accident: _____ Claim Number: _____

PLEASE TURN OVERLEAF AND COMPLETE BOTH SIDES

MEDICAL HISTORY
NEW PATIENT FORM (Side 2)

- **Please list current medications:** _____

- **Please list previous surgical procedures:** _____
 Operation: _____ Year Performed: _____
 Operation: _____ Year Performed: _____
 Operation: _____ Year Performed: _____

- **Do you smoke cigarettes?** Yes No If so how many and for how long? _____

- **Do you take any blood thinning agents (eg warfarin, plavix, aspirin, asasantin)?** Yes No
 Details: _____

- **Do you have any allergies?** Yes No If yes please include details: _____

- **Please indicate if you suffer or have suffered from any of the following:**

| | | | | | |
|---------------------------------|--|--------------------|--|-----------|--|
| Deep venous thrombosis (DVT) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pulmonary embolism (PE) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Open Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary Stent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis/chronic infection: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma / COAD | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

 Other: _____

PRIVACY

All information collected by this practice will be used for providing healthcare. Collection and utilization and storage of this information will be compliant with the 2001 Health Records Act.

I consent to Mr Paul Smith collecting and storing my health information:

Signature: _____ **Date:** ___/___/___

Name: *(Please Print)* _____

REFERRAL SOURCE

- How did you hear about us?** Referred by Doctor: GP or Specialist _____
- Our Website or Royal Australian College of Surgeons (RACS) website
- Google Yellow Pages White Pages Personal recommendation: _____
- Other: _____

All Appointments, Enquiries & Correspondence:

[Form Last Updated: 20 July 2021]