Park Clinic ORTHOPAEDICS | TERENCE CHIN
FOOT & ANKLE SURGEON
MBBS FRACS

Level 8 166 Gipps Street
East Melbourne VIC 3002

T (03) 9116 5827
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Title: First Name:___________________Surname:______________________________

Address:____

Suburb: __________________________________ Postcode: _________________

Phone: Home: __________________ Work: __________________ Mobile: _____________

Email Address: ____ Occupation: _______________________

Date of Birth: _______________________ Current Age: _______

Emergency Contact: __________________________ Relationship: ___________ Phone: ________

Name of your referring doctor:____

Name & Address of family doctor (if different): ____

Name & Address of Physiotherapist or Podiatrist____

Do you have Private Health Insurance: Yes No

Health Fund Name: __________________________________ Health Fund Membership No: ____________

Medicare No: ____________________________ **(Number <u>must be</u> 10 digits)** Number next to name:_____

Do you have an aged pension Card Yes No Card No:_____________________________

Do you have a Veterans Affairs Card: Yes No Card No: ____________________________

Colour of DVA Card: ____________________

Workcover:

Claim No: ________________________________Date of Injury/Accident: ___________

Name of employer____

Insurance Company: ____

Insurance Company Address:____

Case Manager: _______________________________

Phone: ________________________________ Fax: ___________________

TAC: Claim No: ________________________ Date of Injury/Accident: __________

Notice about fees:

A standard consultation is $240 and review $110.

The cost of the consultation is above the Medicare schedule fee. This means you will not recover the full fee after claiming from Medicare. Accounts are payable at the time of consultation. There may be additional charges for further procedures eg. Injections/x-rays.

TAC and WorkCover: the initial account of $240 will be the responsibility of the patient.

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I have read the above, and agree to abide by the payment terms of this practice:

PRINT NAME: ______________________________________ DATE: __________

Are you a smoker? Yes No If yes, how many cigarettes/ day: __________________

Are you aware that smoking has serious adverse effects on skin and bone healing? Yes No

Do you have any of the following pre-existing medical conditions? (Please Tick)

Heart disease High Blood Pressure Lung Disease Asthma Diabetes Blood Clots

BleedingDisorder Stomach Ulcers If not listed: ____________________________________

Have you had any problems with a previous anaesthetic: Yes No

Do you have any allergies: Yes ☐ No ☐ If yes please list_______________________________

Are you on any of the following drugs? **(Please Tick)**

Warfarin Aspirin Clopidogrel Insulin Methotrexate Prednisolone Other

If other, please list: ____

Have you had any of the following in the last 12 months? **(Please Tick)**

Heart Attack A Stent or Pacemaker Inserted

Have you ever had a Deep Vein Thrombosis/Pulmonary Embolism (clot in leg or lung)? Yes No

Area of Problem

Toe Foot Ankle Achilles Heel Bunions

Which side is more painful? Right Left Both

How long have you had pain: Weeks Months Years

Please describe when you first noticed the problem:

____

When does the pain occur? Resting Walking Running Night

What relieves your pain? Rest Orthotics Anti-inflammatories

What worsens your pain? Uneven Ground Stairs Sport Shoes

Pain level/ frequency: Nil Mild Moderate Severe Occasional Constant

What previous treatment have you had for your pain:

Orthotics (Hard/Soft) Physiotherapy Anti-Inflammatories Surgery

Cortisone Injection Other

Office Use Only

Examination

X-ray Treatment Item Numbers