

# NEW PATIENT FORM

To assist us with patient records, please fill in the following questionnaire:

**Date:** ..... / ..... / .....

## Contact Details

**Title:** ..... **First name:** ..... **Surname:** .....

**Address:** .....

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

**Telephone:** Home: ..... Work: ..... Mobile: .....

**Email:** .....

**Date of birth:** ..... / ..... / ..... **Current age:** .....

**Occupation:** .....

**Next of kin:** ..... **Contact No:** .....

**Private Health Insurance Fund:** .....

Member number: .....

**Medicare card No:** \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ **REF No:** .....

**Pension Card No:** .....

**Veterans Affairs Care Card No:** ..... **Gold Card:** YES / NO

**Name of your referring Doctor:** .....

Practice details: .....

**Name of your Family Doctor** (if different from referring): .....

Practice details: .....

**Name of your Physiotherapist:** .....

Practice details: .....

**Name of your Podiatrist:** .....

Practice details: .....

Please note: In order to obtain Medicare rebates your are required to have a valid referral for every appointment. If you are unsure if your referral is valid please speak with our reception staff.

## For All Patients:

*I hereby agree to pay all associated fees relating to my consultation/s and/or surgery (for which a separate quote will be provided for all surgeries), performed by Mr Chin. I acknowledge that if an account is overdue, Mr Chin reserves the right to refer the account to a collection agency. I agree to meet all reasonable costs and commissions incurred in employing the said agency, to collect the overdue account. I have read and understood this fee arrangement.*

*The personal health information that you provide your consultation and subsequent treatment will be collected for the purpose of providing you with high quality health care. Our policy is to protect your privacy and this information will only be disclosed to other health care workers where necessary or required under legislation. I agree and consent to my health information being used in accordance with the Victorian Health Records Act, 2001*

*Mr Chin is involved in the development of orthopaedic instruments and implants. As part of this he may receive payments and royalties. Should you have any queries or concerns regarding this matter or any of the contents regarding this matter or any of the concerns of this registration please feel free to raise them with Mr Chin himself or the administration staff.*

**Patient Signature:** .....

**Date:** ..... / ..... / .....

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## WorkCover:

**Date of injury:** ..... / ..... / .....

Claim number: .....

**Name of Insurance Company:** .....

Insurance Company address: .....

**Case Manager Name:** .....

Phone: .....

Email: .....

**Employer name:** .....

Employer address: .....

Telephone: ..... Contact: .....

## TAC:

**Date of injury:** ..... / ..... / .....

Claim No: .....

**Case Manager Name:** .....

Phone: ..... Email: .....

**Patient Name:** ..... **Date:** ..... / ..... / .....

### Health Questionnaire:

Please read the following and tick if it is applicable to you:

**Are you diabetic?**       Yes     No

**Are you a smoker?**       Yes     No If Yes, how many per day? .....

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

#### Are you on the following drugs?

Warfarin       Yes     No      Aspirin       Yes     No      Iscover       Yes     No  
Clopidogrel       Yes     No      Insulin       Yes     No      Methotrexate       Yes     No  
Prednisolone       Yes     No

**Do you have any allergies?**       Yes     No

If so, please list: .....

**Have you had any problems with a previous anaesthetic?**       Yes     No

If so, please describe: .....

#### Have you had any of the following in the last 12 months:

Acute Myocardial Infarct (heart attack)?       Yes     No  
Had a Stent or Pace maker inserted?       Yes     No

**Have you ever had a Deep Vein Thrombosis / Pulmonary Embolism?**       Yes     No

**Do you live alone?**       Yes     No

If **Yes**, do you have someone close to you that can help you recuperate?       Yes     No

**Do you have stairs at home?**    No     Yes

**At work are you mainly?**       Seated     Standing     Walking     50/50

**Can you modify work for a time after surgery?**       Yes     No

**Do you realise that excess weight significantly increases your risk of complications?**       Yes     No

**Patient Name:** ..... **Date:** ..... / ..... / .....

## Health Questionnaire:

Please read the following and tick if it is applicable to you:

**Area of problem:**

- Toe       Foot       Ankle  
 Achilles       Heel       Bunions

Side:       Right       Left       Both

Duration of problem:       Weeks       Months       Years

Please describe onset:

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

**Pain occurrence:**       Resting       Walking       Running       At night

Exacerbated by:       Uneven ground       Stairs       Sport       Shoes

Improved by:       Rest       Orthotics       Anti Inflammatories       Other

**Pain level:**       Nil       Mild       Moderate       Severe       Intermittent

**Activity level:**       Normal       Reduced walking/ running

**Previous treatment:**       Orthotics (Hard / Soft)       Physiotherapy       Surgery

Cortisone injection       Anti Inflammatories

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## OFFICE USE ONLY

Examination