PATIENT INFORMATION & CONSENT FORM

PERSONAL DETAILS:

Dr / Mr / Master / Mrs / Ms / Miss / Other (Please circle) Surname: _____

First Name: _____ Middle Name: _____ Preferred Name: _____

Address: _____

Suburb: _____ Postcode: _____ Date Of Birth: ____ / ____ / ____

Home Number: _____ Work Number: _____ Mobile: _____

Email: _____

Occupation: _____ Hobbies:_____

Medicare Number: __ __ __ __ __ __ __ __ __ __ __ Reference number: __ Exp: _____

Private Health Fund: _____ Membership Number: _____

For children please list parent details: Parent Name:_____

Medicare number: __ __ __ __ __ __ __ __ __ __ Ref: __ DOB:___/___/___

DEPARTMENT OF VETERANS' AFFAIRS:

Card Number: _____ Card Type (Please circle): Gold White

GENERAL PRACTITIONER DETAILS:

Usual General Practitioner: _____

Name of Surgery: _____

EMERGENCY CONTACT / NEXT OF KIN DETAILS:

Name: _____ Relationship To Patient: _____

Home Number: _____ Mobile: _____

WORKERS COMPENSATION: (please note you will be responsible for your account if your claim is not approved)

Employer/Company Name: _____

Address: _____ Suburb: _____ Postcode: _____

Contact Name: _____ Phone Number: _____

Insurance Company Name: _____ Claim Number: _____

Date of Injury: ____ / ____ / ____ Contact Name: _____ Phone Number: _____

MOTOR VEHICLE CLAIM:

Insurance Company Name: _____ Claim Number: _____

Date of Injury: ____ / ____ / ____ Contact Name: _____ Phone Number: _____

AUTHORITY TO RELEASE MEDICAL/PERSONAL INFORMATION & FEE AGREEMENT

I authorise and request Dr Matthew Lawson-Smith (YARM Nominees Pty Ltd) to release to my referring medical practitioner, and/or other medical practitioners who may be involved with my medical care, now and in the future, all such medical reports, personal information and documentation relevant to my medical care, including procedure reports, test results and hospital admissions, that may be required. I agree that I am responsible for the payment of all fees to Dr Matthew Lawson-Smith (YARM Nominees Pty Ltd) for consultation, surgery or any reports requested on my behalf for medicolegal reasons.

Signed: _____ Dated: ____ / ____ / ____

PATIENT HISTORY

Patient Name: _____ Age: _____ Height: _____cm Weight: _____kg

Do you have: (If yes, please provide details)

Heart problems: Yes No _____

High blood pressure: Yes No _____

Breathing problems: Yes No _____

Diabetes: Yes No _____

Stomach ulcers or reflux: Yes No _____

Kidney problems: Yes No _____

Are you a smoker? Yes No How many per day? _____

Are you on Aspirin, Warfarin or any other blood thinning medications? Yes No

If yes, please list: _____

Do you have allergies to any medications? Yes No

If yes, please list: _____

_____

Please list any other medical conditions:

_____

_____

Please list any previous relevant or major operations:

_____

_____

Please list all the medications you are CURRENTLY taking (including pain relief, non-prescription and herbal):

Name of Medicine/tablets	Dose/Amount	Time taken