

PATIENT INFORMATION SHEET**Mr Sam Joseph****Private & Confidential**

Dr/Mr/Mrs/Ms/Mst/Miss/They/Them..... D.O.B.....

(Given Name)**(Surname)**

Address..... Postcode.....

Phone (H)..... (M).....

Email Address Occupation

Referring Doctor's Name

GP's Name

GP's Address.....

Other health professionals involved (Example Physio):

.....

Medicare No: _____ Card Ref No: _____ Expiry: ____ / 20____
(next to name)

Health Fund.....Membership Number.....

Dept. of Veteran Affairs No..... DVA Card Colour.....

Is this a possible TAC/Workcover claim? YES / NO If YES: Please see our staff.

NEXT OF KIN Relationship

Number

GENERAL HEALTH:

Height:..... Weight:.....

Allergies?

History of; Heart Attack: YES / NO Stroke: YES / NO Epilepsy: YES / NO

Lung problems: YES / NO Diabetes YES medication _____/NO

COVID: YES date: _____/NO

Significant Medical History including active problems:

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Have you or an immediate family member ever had a BLOOD CLOT or DVT? YES / NO

If YES, please provide details:

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Medications?

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Do you take blood thinners? YES / NO If YES, please provide details:

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PARENT/GUARDIAN DETAILS (if patient is under 18 years old)

Dr/Mr/Mrs/Ms/Mst/Miss..... D.O.B.....

(Given Name) (Surname)

Address..... Postcode.....

Medicare No: _____ Card Ref No: _____ Expiry: ____ / 20____

Your consent is required:

FINANCIAL CONSENT: I understand that there are expenses associated with private practice medical and surgical care that are not fully rebatable by Medicare or health funds.

Patient Signature..... **Date**.....