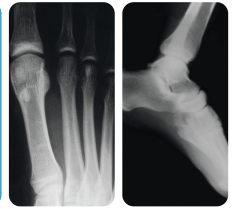


New Patient Form



Mercy Private Hospital

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

Contact Details

Patient name:

Address:

Suburb: **Postcode:**

Telephone: Home: Work:

Mobile: Email:

Date of birth: / / **Age:**

Occupation:

Next of kin:

Phone: Mobile:

Name of your referring Doctor:

Contact details:

Name of Physiotherapist:

Contact details:

Name of Podiatrist:

Contact details:

Private Health Insurance Fund:

Member number:

Medicare Card Number: _____ **REF**
Number: **Valid to:** /

Pension Card /Health Care Card Number:

Veterans Affairs Care Card Number: **Gold Card:** YES / NO

A referral (within 12 months) from your Doctor is required for your Medicare refund.

Terence Chin
MBBS FRACS
Orthopaedic Surgeon
Phone (03) 9928 6450
Fax (03) 9417 0433

The Park Clinic
Specialised Orthopaedics
www.theparkclinic.com.au

New Patient Form

WorkCover:

Date of injury: / /

Claim No:

Name of Insurance Company:

Insurance Company Address:

Telephone: Contact:

Employer name:

Employer Address:

Telephone: Contact:

TAC:

Date of accident: / /

Claim No:

Please refer to the attached information sheet for consultation fees

I hereby agree to pay all associated fees relating to my consultation/s and/or surgery, 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.

Patient Signature:

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 any of 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

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 **No**, with Husband Wife Partner Parents Friend

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

Do you have stairs at home? Yes No

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

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 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 Quite Limited

Previous treatment: Orthotics (Hard / Soft) Physiotherapy Anti inflammatories
 Cortisone Injections Surgery Other

OFFICE USE ONLY

Examination

X Ray

Treatment