DAMIANI ORTHOPAEDICS PATIENT INFORMATION FORM

Reset Form

PATIENT DETAILS

Title: ..... First Name: ..... Surname: .....

DOB: ...../...../..... Mobile: .....Landline: .....

Residential Address: .....Suburb: .....Postcode: .....

Email· .....

EMERGENCY CONTACT

Name: ..... Relationship to you: ..... Mobile: .....

Parent/Guardian Name (if under 18) ..... Parent/Guardian DOB: .....

ACCOUNT DETAILS

Medicare Number: ..... Exp Date: ...../..... Reference Number: .....

Private Health Fund: ..... Number: ..... Reference Number: .....

VETERAN AFFAIRS PATIENTS ONLY DVA Number: ..... DVA Card Colour

REFERRAL

Referring Doctor: ..... Regular GP: .....

If your GP is not your referring Doctor, would you like copies of your reports sent to them? ◯ Yes / No ◯

Is this consultation related to a Third Party/Medical Legal Claim? ◯ **Yes / No** ◯

Is this consultation related to a Workers compensation claim? ◯ **Yes / No** ◯

If so, please fill in the following details:

Insurance Company: ..... Claim Number: ..... Date of injury: .....

Address: .....State: ..... Postcode: .....

Phone: .....Fax: ..... Contact Person: .....

PLEASE NOTE:

Your consultation is in the private rooms of a private clinic. Full payment for consultation, plasters, bandages, splints, braces and any other clinical resource is required at the time of consultation unless prior, documented arrangements have been made with this office. An account keeping fee will be charged for any outstanding accounts. Your Medicare rebate will be processed upon payment of your account. It is not the policy of the practice to bulk bill for any services rendered. If you are having difficulties paying please discuss with reception prior to your consultation.

- I understand that I will be notified by Damiani Orthopaedics of any clinically relevant pathology results pertaining directly to my surgery.
- I agree to the above conditions and give my consent for medical information concerning myself or my child to be released to my insurer, employer, solicitor, my referring GP and other health professionals. I give consent to the above information and any other relevant medical information being scanned and stored in my electronic patient file.

Signed· ..... Name· .....Date: ...../...../.....

DAMIANI ORTHOPAEDICS MEDICAL HISTORY FORM

Past operations	Hospital	Year

Current Medications	Dose/Frequency	Reason

Please circle your response

DO YOU SUFFER FROM ANY OF THE FOLLOWING? (Please select)

High Blood Pressure ☐	Bleeding disorder ☐	Stomach ulcers/reflux ☐	Heart disease ☐
Leg cramps ☐	Epilepsy ☐	Heart attack ☐	Asthma/airway disease ☐
Liver disease ☐	Angina/chest pain ☐	Bronchitis ☐	Hepatitis B or C ☐

Do you take any of the following?

Aspirin / Plavix / Isocover ◯ Yes / No ◯

Oral Contraceptive / Hormone replacement therapy ◯ Yes / No ◯

Have you or any of your relatives experiences issues with anaesthetic/s? *(including confusion?)* ◯ Yes / No ◯

If so, please describe the problem : .....

Do you or have you ever smoked? ◯ Yes / No ◯ If you have stopped, when did you quit? .....

Do you drink alcohol? ◯ Yes / No ◯ If yes, how many per week?.....

Do you have any reason to believe you are pregnant? ◯ Yes / No / NA ◯

Have you ever has blood clots in the legs or lungs? Yes / No

If yes, when ..... Treatment: .....

Has a member of your family ever suffered from blood clots in the legs or lungs? ◯ Yes / No ◯

Have you ever had a blood transfusion? ◯ Yes / No ◯

If yes, when..... Any problem / reaction? Yes / No

Allergy	Reaction