

# NEW PATIENT FORM

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

## Contact Details

Date:

Title:  First name:  Surname:

Address:

Suburb:  Postcode:

Telephone: Mobile:  Work:

Email:

Date of birth:  Current age:

Occupation:

Next of kin:  Relationship:  Contact No:

Private Health Insurance Fund:

Member number:

Medicare Card No: \_\_\_\_\_ REF No:

Pension Concession Card (blue) No: CRN \_\_\_\_\_ EXP:

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 you 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      If Yes, list medication:

**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

Ozempic / Mounjaro / similar  Yes  No

Clopidogrel  Yes  No

Insulin  Yes  No

Methotrexate  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?**  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

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  Quite limited

**Previous treatment:**  Orthotics (Hard / Soft)  Physiotherapy  Anti Inflammatories

Cortisone injection  Surgery  Other

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## OFFICE USE ONLY

Examination

X Ray

Treatment

Item Numbers: