

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:

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

OFFICE USE ONLY

Examination

X Ray

Treatment

Item Numbers: