TERENCE CHIN
FOOT & ANKLE SURGEON
MBBS FAOrthA

Park Clinic ORTHOPAEDICS

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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 your 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: