Perth Neurosurgery - A/Prof Stephen Lewis

NEW PATIENT REGISTRATION FORM

TITLE: Prof / Dr / Mr / Mrs / Ms / Miss (Please circle)

SURNAME: _____ GIVEN NAMES: _____

ADDRESS: _____

SUBURB: _____ STATE: _____ P/CODE: _____

DOB: _____ AGE: _____ MALE or FEMALE (Please circle)

OCCUPATION: _____ LEFT or RIGHT-HANDED (Please circle)

PHONE (H): _____ (W): _____ (M): _____

EMAIL ADDRESS: _____

MEDICARE NO: _____ *REF NO: _____ EXPIRY DATE: _____

*(number located to left of your name on Medicare card)

PENSION/HCC NO: _____ EXPIRY DATE: _____

PRIVATE HEALTH FUND: _____ MEMBERSHIP NO: _____

DOES THIS COVER HOSPITAL ADMISSION: YES / NO (Please circle) LEVEL OF COVER: _____

IS YOUR APPOINTMENT RELATED TO WORKERS COMPENSATION: YES / NO (Please circle)

DATE OF ACCIDENT: _____ CLAIM NO: _____

EMPLOYER: _____ PH: _____

EMPLOYER'S ADDRESS: _____

CASE MANAGER: _____ EMPLOYER'S INSURANCE COMPANY: _____

REFERRING DOCTOR: _____ CLINIC: _____

USUAL FAMILY DOCTOR NAME: (if different from referring doctor) _____

GP ADDRESS: _____ **SUBURB:** _____ **PHONE:** _____

NEXT OF KIN: _____

RELATIONSHIP: _____ TELEPHONE: _____

PLEASE INDICATE IF YOU TAKE THE FOLLOWING MEDICATIONS: (Please circle)

1. Asprin	YES / NO
2. Warfarin	YES / NO
3. Plavix	YES / NO
4. Clopidoril or other antiplatelet or blood thinning medications	YES / NO
5. Fish Oil Supplements	YES / NO
6. Anti-Inflammatory Medication	YES / NO

CURRENT MEDICATIONS YOU ARE TAKING:

	NAME	DOSE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PLEASE LIST ANY ALLEGIES YOU HAVE:

_____

PLEASE INDICATE IF YOU SUFFER / HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS: (Please circle)

1. High Blood Pressure	4. Heart Attack	7. Angina	10. Asthma
2. Open Heart Surgery	5. Cardiac Stent	8. Stroke / TIA	11. Diabetes
3. Chronic Infection	6. Migraines	9. DVT / PE	12. Notifiable Disease

PLEASE LIST ALL OTHER DOCTORS YOU ARE SEEING:

	NAME	SPECIALITY	LOCATION
1.			
2.			
3.			
4.			
5.			

PLEASE LIST ANY PREVIOUS SURGERY:

	DATE	SURGERY	SURGEON	COMPLICATIONS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

DO ANY OF THE FOLLOWING DISEASES RUN IN YOUR FAMILY: (If yes, please circle)

1. Heart Disease
2. High Blood Pressure
3. Diabetes
4. Cancer – type_____
5. Brain or Spinal Cord Tumours – type_____
6. Other_____

DO YOU CURRENTLY SMOKE CIGARETTES?:

No Yes If yes, how many cigarettes / day?_____

If you don't currently smoke, did you smoke in the past? No Yes When did you give up_____

DO YOU DRINK ALCOHOL?:

No Yes If yes, how many drinks / day_____

DO YOU USE RECREATIONAL DRUGS?:

No Yes

ARE YOU AT RISK FOR AIDS? (Sexual orientation, drug abuse, previous blood transfusions)

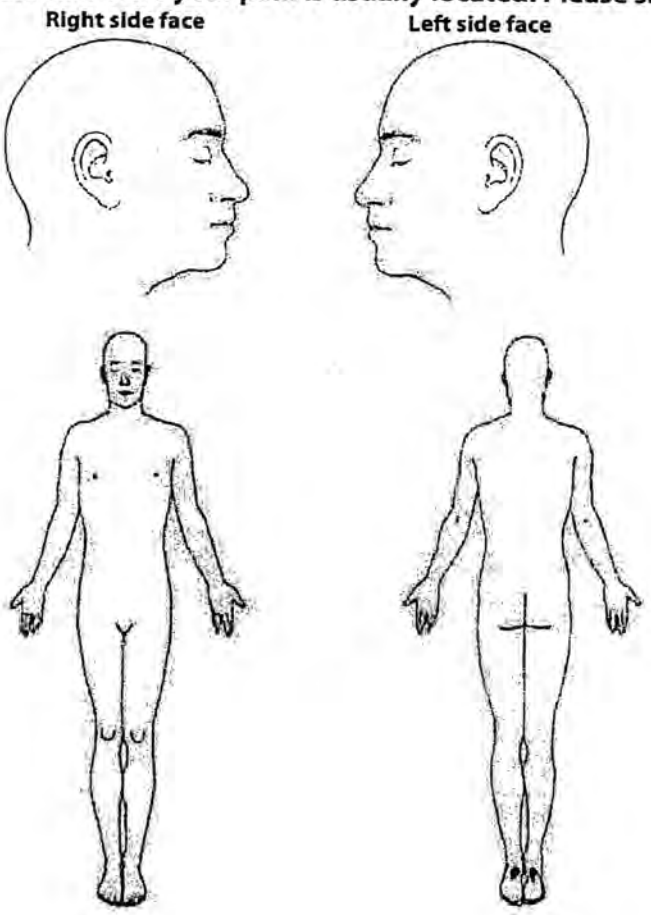
No Yes If yes, please explain_____

ARE YOU OR COULD YOU BE PREGNANT?:

No Yes

ON A SCALE OF 1 TO 10 WITH 10 BEING THE MOST EXTREME PAIN IMAGINABLE AND 1 BEING NO PAIN AT ALL WHAT IS YOUR CURRENT LEVEL OF PAIN EVERY DAY?:_____

On the diagram below indicate where your pain is usually located. Please shade the painful areas.



PRIVACY ACT 1988

PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

We require your consent to collect, use and disclose personal information about you. Please read this information carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care to properly advise and treat you. Such information may include:

- Full medical history
- Family medical history
- Ethnicity
- Personal contact and health fund details
- Genetic information

Both our practice staff and medical practitioners may participate in the collection of this information.

This information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources such as other doctors, other health providers or hospital.

With your consent, we may use the information you provide us with, in the following ways:

- Administrative purposes in running our medical practice
- Account keeping and billing purposes
- Disclosure to others involved in your health are, including treating doctors and specialists outside this medical practice, including other health care providers and insurance/health fund companies This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following such referrals.
- Disclosure for research and quality assurance activities to improve individual and community health care practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.
- Where legally required, such as providing records to court, mandatory reporting or child abuse or the notification of certain communicable diseases.

You are entitled to access your own health records at any time convenient to both yourself and the practice except in some circumstances where access might legitimately be withheld or where your request is frivolous. A charge may be imposed for processing your request. Where you disagree with the accuracy of the information recorded please discuss this with your doctor as you are entitled to have your corrections included in your file.

CONSENT

I have read the information above and I provide my consent for A/Prof Stephen Lewis and associated practice staff to collect, use and disclose my personal information as outlined above.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so, may compromise the quality of the health care and treatment given to me.

I understand that I am entitled to access my own health care records except where access might be legitimately withheld. I understand that I will be given an explanation in these circumstances.

I understand that I may withdraw my consent to the use and disclosure of my personal information (except where legal obligations must be met).

SIGNATURE (patient) _____ DATE: _____

I understand that payment of my account is my responsibility and is to be settled on the day of service and that my health fund / medicare / insurer may not cover the total amount invoiced

I understand that I will be responsible for payment of debt collection fees applied to overdue accounts. I understand that a cancellation fee of $50.00 may apply for less than 24 hours' notice to cancel an appointment or failure to attend an appointment.

SIGNATURE: _____ DATE: _____