The Gold Coast Centre for
Bone & Joint Surgery

PERSONAL INFORMATION

TITLE: SURNAME: CHRISTIAN NAME:

D.O.B.: PREFERRED NAME:

OCCUPATION:

ADDRESS:

POSTAL ADDRESS: (If differs from above):

TELEPHONE: H W M

E-Mail:

PREFERRED CONTACT METHOD: ▢ Phone ▢ Email

GP:

HEALTH INSURANCE

MEDICARE NO: PATIENT NO: EXPIRY:

PENSION CARD NO: EXPIRY:

VETERANS (DVA) NO: ▢ WHITE ▢ GOLD

HEALTH FUND: MEMBERSHIP NO:

EMERGENCY CONTACT/ NEXT OF KIN

NEXT OF KIN: RELATIONSHIP TO PATIENT:

CONTACT PH:

PATIENT AUTHORITY: In the event that I am unable to be contacted, I give permission for the employees of the Gold Coast Centre for Bone and Joint Surgery to speak with and relay information (e.g. surgery particulars, admission times, appointments and office accounting) to the above nominated contact.

FOR ADMINISTRATION PURPOSES, THIS OFFICE IS OFTEN REQUIRED TO CONTACT YOU BY PHONE.
I AUTHORISE STAFF TO:

▢ IDENTIFY THE NAME OF THE PRACTICE
▢ LEAVE A MESSAGE ON ANSWERING MACHINE/ VOICE MAIL

SIGNATURE: DATE:

This medical practice collects medical information for the purpose of providing needed health care. We require you to provide a full medical history in order that we may deliver relevant and necessary treatment.

DISCLOSURE/ COLLECTION STATEMENT

I consent to the disclosure to and collection from, medical practitioners, allied health practitioners and hospitals that may require information about my medical / surgical history but only to the extent necessary to assess / treat the condition that I have consulted my orthopaedic specialist about. Disclosure and collection may also be required for administrative purposes for the efficient running of our practice, including Medicare, DVA and health funds and non medical information for debt collection if applicable.

SIGNATURE: _____ DATE: _____

MEDICAL/ SURGICAL HISTORY

☐ High Blood Pressure	☐ DVT / PE	☐ Stroke (CVA)
☐ Peripheral Vascular Disease	☐ Renal (kidney) Disease	☐ Thyroid Disease
☐ Diabetes : Insulin Dependent Oral Medication	☐ Rheumatoid Arthritis	☐ Peptic Ulcer
☐ Ischaemic Heart Disease	☐ Cardiac Stents	☐ Cardiac Bypass (CABG)
☐ Lung Disease/ Asthma		

HEIGHT: WEIGHT:
SPECIALISTS INVOLVED IN CARE (E.G. CARDIOLOGISTS):
PREVIOUS SURGERY:
ALLERGIES/ REACTION:
MEDICATION:
CIGARETTES: _____ per day ALCOHOL: _____ per day/ per week