The Gold Coast Centre for
Bone & Joint Surgery

PERSONAL INFORMATION

Surname: _____ First Name: _____

Preferred Name _____ DOB: _____/_____/_____

Occupation: _____ Email: _____

Address: _____

Postal Address: _____

Phone: M_____ H_____

Health Fund Name: _____

WorkCover Claim ID: _____ Case Manager: _____

Case Manager Contact Details: _____

GP & REFERRING DR DETAILS

(If same as GP leave blank)

Usual GP: _____ Referring Dr:_____

GP Practice Name:_____

EMERGENCY CONTACT/NEXT OF KIN

Next of Kin: _____ Relationship_____

Phone. M_____ H_____

MEDICAL/SURGICAL HISTORY

Please Select all that apply to you:

☐ High Blood Pressure ☐ DVT / PE ☐ Heart ☐ Bleeding Disorder

☐ Diabetes ☐ Renal (kidney) Disease ☐ Lung (Asthma, COPD etc)

Height:_____ Weight: _____

Other Specialist(s) involved in your care: _____

_____

Previous Surgery: _____

_____

Allergies/Reactions: _____

Current Medication: _____

Do you smoke: ☐ **Yes** ☐ **No** **Do you drink alcohol:** ☐ **Yes** ☐ **No**

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***