MR Sam PATTEN
ORTHOPAEDIC HIP & KNEE SURGEON

Main consulting rooms
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Patient Registration Form

Personal Details

Title | Surname

First Name | Preferred Name

Date of Birth | Gender

Pronouns: Please select | Home Phone

Mobile | Work Phone

Email Address

Address

Suburb | Postcode | State

Medicare and Insurance

Medicare No. | Reference No. | Expiry

Health Fund | Membership No.

DVA No. | DVA Card Colour ☐ White ☐ Gold

If holding a DVA white card, what condition/s does this cover?

Referring Doctor

Name | Phone

Address

Usual GP (if different from referring doctor)

Name | Phone

Address

Emergency Contact

First Name | Surname

Phone No. | Relationship to You

Medical History

Are you currently a smoker? ☐ Yes ☐ No No. of cigarettes per day

Do you have diabetes? ☐ Yes, type 1 ☐ Yes, type 2 ☐ No

If yes, what is it treated with? ☐ Tablets ☐ Insulin injections or pump ☐ Diet only

Have you ever had any of the following: ☐ Heart attack ☐ Stroke/mini stroke ☐ No
☐ Blood clot (DVT/PE) ☐ Irregular heartbeat

Have you ever contracted any of the following bacterial infections: ☐ MRSA ☐ CRE ☐ MRSE
☐ VRE ☐ ESBL ☐ No

Do you have any of the following: ☐ Pacemaker ☐ Defibrillator ☐ No

If yes, please provide the brand name

Have you ever had heart surgery? ☐ Yes ☐ No

If yes, please provide details

Cardiologist Details (if applicable)

Name Phone

Address

Medications

If all your medication is not outlined on your doctor's referral, please list all your current medications below, as well as dosage and frequency where possible.

Allergies

Please list any allergies you have.

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Patient Consent

Mr Sam Patten is collecting your health information to provide you with health services. Please read and give consent below for this information to be collected and stored. You may access your health information by writing to us. Your medical information will be used for providing health care in the following ways:

- To gain a history, and diagnose and treat condition or disease where necessary;
- Administrative purposes in running this Practice;
- Writing reports to your doctor and other health practitioners involved in the provision of your healthcare, and the storing of reports provided to this Practice by other health practitioners or third parties; and
- Billing and collection purposes, including but not limited to compliance with private health fund/s, Medicare, and health insurance commission requirements. If you do not consent to providing us with your health information, we may be unable to provide you with health services.

I have read the above and consent to Mr Sam Patten collecting my health information.

I give permission for Mr Sam Patten and his staff to contact me by email, SMS and/or telephone and if necessary, leave a voicemail message.

I consent to Mr Sam Patten's practice communicating with me and my emergency contact/s via the above provided phone number/s, email address/es and or/mailing address/es, including receiving my health information.

Please print name and sign below (guardian to complete if patient is under 18 years of age).

If you are unable to sign below electronically, please print this page and sign by hand.

Name (please print):

Signature:

Date: