SAM PATTEN
ORTHOPAEDICS
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Provider No. 201879CB
HIP & KNEE SURGEON
JOINT REPLACEMENT
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Patient Registration Form

Title: _____ Surname: _____ First name: _____

Postal address: _____

Suburb: _____ Postcode: _____

Email address: _____

Occupation: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Medicare & Health Insurance

Medicare Number *(10 digits)*: _ _ _ _ _ _ _ _ _ _ Ref No *(digit next to your name)*: _ Expiry: _ _ / 20_ _

Private Health Insurance Fund: _____ Membership Number: _____

Veterans Affairs Card Number: _____ White / Gold Card *(please circle)*

Next of Kin Details

Name: _____ Relationship to you: _____

Next of Kin phone number: _____

Referring Doctor: _____

Address: _____

Telephone: _____ Fax: _____

Usual GP: _____

Address: _____

Telephone: _____ Fax: _____

Physiotherapist: _____

Address: _____

Telephone: _____ Fax: _____

MEDICAL HISTORY & MEDICATIONS

CARDIAC

I have been diagnosed with a heart condition, e.g. irregular rhythm, heart disease: YES / NO

If yes, please describe: _____

I have a pacemaker and/or defribillator: YES / NO If yes, type/brand: _____

I have had a heart attack and/or have had surgery on my heart: YES / NO

If yes, (please circle): STENT / BYPASS SURGERY / VALVE

I have a cardiologist: YES / NO

If yes, provide name, address & phone number: _____

_____

DIABETES

Do you suffer from Diabetes? YES / NO If yes: TYPE 1 / TYPE 2

If yes, is your diabetes controlled by: DIET ONLY / TABLETS / INSULIN INJECTIONS

CURRENT MEDICATIONS

Do you take any blood-thinning medications? If yes, please list: _____

Have you ever had a bleeding or clotting problem? YES / NO

Have you ever had a stroke or mini-stroke? YES / NO

Please list all current medications below:

DRUG NAME	DOSAGE	FREQUENCY

Do you have any allergies? (ie. Medications /Tapes / Dressings / Latex)

_____

_____

CONSENT

We require your consent to collect personal information on your behalf. This medical practice collects information for the primary purpose of providing quality health care. We require that you provide us with your personal details and medical history so we may properly assess, diagnose and treat your health care needs.
We will use the information in the following ways:

- Administration purposes in running the practice
- Billing purposes, including compliance with Medicare, WorkCover & TAC
- Correspondence with others involved in your care, including your GP, treating doctors, physiotherapists and other specialists.

I have read the information above and understand the reasons why my information must be collected. I am aware that this practice has a privacy policy regarding patient information.
I understand that I am not obliged to provide any information requested but that failure to do so may compromise the quality of my treatment.
I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signature: _____
Name: _____
Date: _____

CONSENT TO PARTICIPATE IN RESEARCH *(optional)*

I, _____ am willing to participate in the collection of data for research purposes. (Please note ALL data collected is de-identified).

Signature: _____ **Date:** _____

REFERRAL SOURCE (Please circle)

Website: www.melbourneorthopaedics.net.au
Yellow/White pages
GP Recommendation
Other
Google
Personal Recommendation
Royal Australian College of Surgeons Website