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MARK BLACKNEY
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Park Clinic
ORTHOPAEDICS

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NEW PATIENT FORM

To assist us with patient records, please fill in the following questionnaire:

Contact Details

Patient name: .....

Address: .....

Suburb: ..... Postcode: .....

Telephone: Home: ..... Work: .....

Mobile: ..... Email: .....

Date of birth: ...../...../..... Age: .....

Occupation: .....

Next of kin: .....

Phone: ..... Mobile: .....

Name of your referring Doctor: .....

Contact details: .....

Name of your Physiotherapist: .....

Contact details: .....

Name of your Podiatrist: .....

Contact details: .....

Private Health Insurance Fund: .....

Member number: .....

Medicare card number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ REF No: ..... Valid to: ...../.....

Pension Card/ Health Care Card Number: .....

Veterans Affairs Care Card Number: ..... Gold Card: YES / NO

A referral (within 12 months) from your Doctor is required for your Medicare refund.

Privacy:

I, (print name): .....

Of (address): .....

Consent to Park Clinic Orthopaedics collecting, holding, using and disclosing my personal information (including health information and other sensative information) as set out in their collection statement.

Patient Signature: .....

Date: ...../...../.....

Please refer to the attached information sheet for consultation fees

I hereby agree to pay all associated fees relating to my consultation/s and/or surgery, performed by Mr Blackney.
I acknowledge that if an account is overdue, Mr Blackney reserves the right to refer the account to a collection agency.
I agree to meet all reasonable costs and commissions incurred in employing the said agency, to collect the overdue account.
I have read and understood this fee arrangement.

Patient Signature: .....

Date: ...../...../.....

Health Questionnaire:

Please read the following and tick if it is applicable to you:

Are you diabetic? ◯ Yes ◯ No

Are you a smoker? ◯ Yes ◯ No If Yes, how many per day? .....

If Yes, are you aware that smoking has serious adverse effects on skin and bone healing? ◯ Yes ◯ No

Are you on the following drugs?

Warfin ◯ Yes ◯ No Asprin ◯ Yes ◯ No Iscover ◯ Yes ◯ No

Clopidogrel ◯ Yes ◯ No Insulin ◯ Yes ◯ No Methotrexate ◯ Yes ◯ No

Prednisolone ◯ Yes ◯ No Xarelto ◯ Yes ◯ No

Do you have any allergies? ◯ Yes ◯ No

If so, please list: .....

.....

Have you had any problems with a previous anaesthetic? ◯ Yes ◯ No

If so, please describe: .....

.....

Have you had any of the following in the last 12 months:

Acute Myocardial Infarct (heart attack)? ◯ Yes ◯ No

Had a Stent or Pace maker inserted? ◯ Yes ◯ No

Have you ever had a Deep Vein Thrombosis / Pulmonary Embolism? ◯ Yes ◯ No

Do you live alone? ◯ Yes ◯ No

If **No**, with? ◯ Husband ◯ Wife ◯ Partner ◯ Parents ◯ Friend

If **Yes**, do you have someone close to you that can help you recuperate? ◯ Yes ◯ No

Do you have stairs at home? ◯ Yes ◯ No

At work are you mainly? ◯ Seated ◯ Standing ◯ Walking ◯ 50/50

Can you modify work for a time after surgery? ◯ Yes ◯ No

Do you realise that excess weight significantly increases your risk of complications? ◯ Yes ◯ No