PATIENT DETAILS

Title: Dr / Mr / Mrs / Miss / Ms (please circle)

Surname : ..... First Name: .....

Date of Birth : ..... Occupation : .....

Address : .....

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

Ph (h) : ..... Ph (w) : ..... Mobile: .....

Do you wish to receive confirmation of appointments by SMS? Yes ❑ No ❑

MEDICAL CONDITIONS AND MEDICATION:

Are you diabetic: Yes/No. Do you suffer from epilepsy? Yes/No.

Do you suffer from high blood pressure? Yes/No. Do you suffer from cardiac problems ? Yes/No

Do you have a pacemaker? Yes/No. Do you a prosthetic heart valve or stent? Yes/No

Are you on Warfarin/Aspirin or other blood thinning medications: Yes/No.

Do you take anti-inflammatory medication? Yes/No. Are you allergic to latex? Yes/No.

MEDICARE / HEALTH FUND / PENSION / VETERANS' AFFAIRS DETAILS

Medicare No : .....Number in front of your name..... Expiry Date: ...../.....

Private Health Fund : ..... Membership No : .....

Veterans Affair No : .....

Pension / Health Care Card No : ..... Expiry Date :..... /..... / .....

WORKCOVER DETAILS

Date of injury : ____ / ____ / _____ Claim No : ..... Accepted : Yes ❑ No ❑

Name of insurer: ... .

Employer : .....Phone: .....

Address : .....

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

REFERRING DOCTOR (Reports will be sent to referral Doctor and / or Family Doctor if specified)

Name of referring doctor : .....

Family doctor's name : .....

Family doctor's address: .....

Telephone No..... Fax.....

NEXT OF KIN

Surname : ..... First Name: .....

Relationship: .....

Phone (h) : ..... Phone (w) : ..... Mobile : .....