Dr Allan Young
New Shoulder Patient Details

Your Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other: _____

First (given) Names*: _____ Surname*: _____

*must be the same as they appear on your Medicare card if you have one

Preferred Name (if any): _____ **Date of Birth:** _____ Age: _____ Gender: Male ☐ Female ☐

Address: _____ Mobile Ph: _____

Suburb: _____ Home Ph: _____ Work Ph: _____

State: _____ Postcode: _____ Email: _____

Account to be sent to (ie parent's name if patient is a child): _____

Next of kin: _____ **(required by law)** Next of kin's mobile number: _____

What is your next of kin's relationship to you?: _____

Medicare Number: _____ Your Ref No on the card: _____ Expiry date: _____

Private Health Fund: _____ Membership No: _____

Please tick if you have a: Pension card ☐ Health Care card ☐ Gold DVA card ☐ or a White DVA card ☐

Card number for the above: _____ What is the card's expiry date?: _____

Name of referring doctor: _____ Is this doctor is a: GP ☐ or a Specialist ☐?

The name of your usual GP (general practitioner) if different from above: _____

GP's address: _____ Phone: _____

Physiotherapist: _____ Phone: _____

Physiotherapist's address: _____

Are you retired? Yes ☐ Semi-retired ☐ No ☐ What is (or was) your occupation? _____

Competitive Sports you play: _____ Other sports: _____

Will your consultation be related to a claim for Workers Compensation? YES ☐ NO ☐? *If you answered **YES**, please complete:*

Workers Compensation Claims ONLY

Date of Injury: _____ Employer's name (company): _____ Phone: _____

Employer's address: _____ Fax or email: _____

Insurance Company: _____ Claim Number (if known): _____

Insurance Company's address: _____ Fax or email: _____

Case Manager's name: _____ Phone (direct number): _____

Case Manager's email address: _____

Consent to Collect Patient Information – Privacy Act 2002

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. **NB:** please refer to our practice *Privacy Policy* online at www.sydneyshoulder.com.au or ask for a copy. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
3. Disclosure to others involved in your care, including doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. 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 understand that if my information is to be used for any purpose other than the above, my consent will be sought. 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 of which I may notify this practice.

I further understand that I am seeking the care of Dr Young for my medical management and that it is a policy of the practice that Dr Young **does not** undertake examinations and/or reports for the purpose of Medico-Legal matters or Third Party claims.

Signed (***NB a digital signature is NOT required***): _____ **Today's Date:** _____

Name (***typed or printed***): _____ Email completed form to reception@sydneyshoulder.com.au

Which Shoulder?

Firstly, please tell us:

Which shoulder is it? Left☐ Right☐ *or* both ☐

and what is your **Hand Dominance**? Left☐ Right☐ *or* ambidextrous☐

Significant Medical and Surgical History

Please list your <u>significant</u> medical history:_____

_____

_____

_____

Please list your <u>significant</u> surgical history:_____

_____

_____

_____

Have you ever had complications after surgery? No☐ Yes☐ *If yes - what complications?*_____

_____

Medications

Please list all **current or regular medications** that you take: _____

_____

_____

_____

Do you take **blood thinners?** No☐ Yes☐ - *if yes, which?* Warfarin☐ Plavix☐ Aspirin☐ other☐: _____

Allergies

Do you have any **allergies to DRUGS?** No☐ Unknown☐ Yes☐ - *if yes, which drugs?*_____

_____

What allergic reaction to drugs do you have? Rash☐ Shortness of Breath☐ Swelling☐ Anaphylaxis☐ other☐: _____

_____

Do you have any history of:

Arthritis
- *Osteoarthritis?* No☐ Yes☐
- *Rheumatoid Arthritis?* No☐ Yes☐

Diabetes? No☐ Yes☐

Epilepsy? No☐ Yes☐

Liver Disease
- *Hepatitis B?* No☐ Yes☐
- *Hepatitis C?* No☐ Yes☐

Stroke(s)? No☐ Yes☐

HIV / AIDS? No☐ Yes☐

Kidney Conditions? No☐ Yes☐

Gastric Problems
- *Indigestion / Reflux?* No☐ Yes☐
- *Stomach Ulcers?* No☐ Yes☐

Venous Conditions
- *DVT (Thrombosis)?* No☐ Yes☐

Thyroid Conditions No☐ Yes☐

Cardiac Problems
- *Heart Attack?* No☐ Yes☐
- *High Blood Pressure?* No☐ Yes☐
- *Other?*_____

_____

Lung Conditions
- *Asthma?* No☐ Yes☐
- *Emphysema?* No☐ Yes☐
- *Sleep Apnoea?* No☐ Yes☐
- *Pulmonary Embolus?* No☐ Yes☐
- *Are you a smoker?* Never☐ Quit☐ Yes☐

Cancer
- *Breast?* No☐ Yes☐
- *Mastectomy?* No☐ Yes☐
- *Other?*_____

_____