NEWCASTLE ORTHOPAEDIC FOOT & ANKLE CLINIC

CONFIDENTIAL PATIENT INFORMATION SHEET

Mr/Mrs/Ms/Miss/Master/Dr (please circle)

Surname ………………………………………………………………….Given name………………………………………………….....D.O.B…………………………..

Residential Address ……………………………………………………………………………. Postal Address (if different)……………………………………………………………

……………………………………………………………………………….P/Code………………… P/Code………………………………..

HomePh:…………………………………………………………………WorkPh:…………………………………………………Mobile…………………………………………………….

Email address: ………………………………………………………………………..…...

Occupation……………………………………………

Medicare Number:…………………………………………………………….Ref No:………………(No in front of your name) Valid to ………/……………….

If under the age of 18-Parent's Name:………………………………………………………DOB………………………………Medicare Reference No:………….

Veterans Affairs No:……………………………………………………………………………….White/Gold

DO YOU HAVE PRIVATE HEALTH INSURANCE? YES /NO (please circle)

Name of Health Fund……………………………………………………………………………Member No……………………………………………Ref No……………………………

Local GP (if not referring Doctor)……………………………………………………………….Address:…………………………………………………………………………………………

MEDICAL HISTORY

Past Operations (Type and Year)

………

………

MEDICAL ILLNESSES- (Please Circle)

Diabetes DVT Pulmonary Embolus Heart Disease Vascular Disease

Do you smoke? Yes / No ……………No. per day………………………

MEDICATIONS- (Please List)

………

………

ALLERGIES – (Please List)………

AUTHORITY – PLEASE READ AND SIGN : I hereby give my consent for medical information concerning myself or my child to be supplied to my referring Doctor and agreed Third Parties. I accept complete responsibility for any accounts pertaining to my care. I understand that information may include photographic images non-identifying that may be used for purposes of medical education.

Patient/Parent/Guardian Signature Date