DR MURRAY BLYTHE | PATIENT INFORMATION & CONSENT FORM

PERSONAL DETAILS:

Dr Mr Master Mrs Ms Miss Other

First Name:	Surname:	Date of Birth:
Address:	Suburb:	Postcode:
Email Address:		
Home Number:	Work Number:	Mobile:
Medicare Number:	Ref (Number next to your name):	Exp:
Private Health Fund:	Membership Number:	
Does your Private Health Fund cover hospital admission?	YES / NO	

GENERAL PRACTITIONER DETAILS:

Usual General Practitioner:

Name of Surgery:

EMERGENCY CONTACT / NEXT OF KIN DETAILS:

Name:	Relationship to Patient:
Home Number:	Mobile Number:

DEPARTMENT OF VETERANS' AFFAIRS:

Card Number: Card Type: Gold White

WORKERS COMPENSATION: (Please note you will be responsible for your account if your claim is not approved)

Employer / Company Name:		
Address:	Suburb:	Postcode:
Contact Name:	Phone Number:	
Insurance Company Name:		Claim Number:
Date of Injury:	Contact Name:	Phone Number:

MOTOR VEHICLE CLAIM:

Insurance Company Name:		Claim Number:
Date of Injury:	Contact Name:	Phone Number:

AUTHORITY TO RELEASE MEDICAL / PERSONAL INFORMATION & FEE AGREEMENT:

I authorise and request Southern Cross Orthopaedic Group to release to my referring medical practitioner, and / or other medical practitioners who may be involved with my medical care, now and in the future, all such medical reports, personal information and documentation relevant to my medical care, including procedure reports, test results and hospital admissions, that may be required. I agree that I am responsible for the payment of all fees to Southern Cross Orthopaedic Group for consultation, surgery or any reports requested on my behalf for medicolegal reasons.

Signed: Dated:

DR MURRAY BLYTHE | PATIENT HISTORY

Preferred Name:	Occupation:	Age:
Height: cm/ft	Weight: kg	Postcode:

DO YOU HAVE:		
Heart problems:	YES / NO	If yes, please provide details:
Breathing problems:	YES / NO	If yes, please provide details:
Diabetes:	YES / NO	If yes, please provide details:
Stomach ulcers/reflux:	YES / NO	If yes, please provide details:
Kidney problems:	YES / NO	If yes, please provide details:
Are you a smoker:	YES / NO	If yes, how many per day:

Are you on Aspirin, Warfarin or any other blood thinning medications? YES / NO

If yes, please list:

Do you have any allergies to any medications? YES / NO

If yes, please list:

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

PLEASE LIST ANY PREVIOUS RELEVANT OR MAJOR OPERATIONS:

PLEASE LIST ALL THE MEDICATIONS YOU ARE **CURRENTLY** TAKING, INCLUDING **PAIN KILLERS** THAT ARE NOT PRESCRIBED:

Name of Medicine / Tablets:	Dose / Amount:	Time Taken: