PATIENT INFORMATION & CONSENT

Title: Mr / Mrs / Miss / Ms / other: _____

First name: _____ **Surname:** _____

Known as / preferred name: _____ **Date of Birth:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Mobile: _____ **Work / Home:** _____

Email address: _____

Medicare number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref:** (number beside your name)_____

Expiry: _____ / _____ **Not Eligible for Medicare:** ☐

Private Health Insurance Fund (Hospital): _____

Member Number: _____ **Uninsured or Extra Only:** ☐

Secondary Contact Person (please provide the details of someone different from the above)

Name: _____ **Relationship to the patient:** _____

Phone: _____ **Email :** _____

Medicare Payee Details for parents claiming the rebate for children under 17 years old ONLY:

Name: _____ Date of Birth: _____

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: _____

Address (only if different to the patient):_____

_____

Workers compensation / ICWA / Insurance claim patients ONLY:

Date of accident:_____ Injury:_____

Employer/Company: _____ Employer contact:_____

Where the injury occurred:_____

How the injury occurred:_____

Employer's Insurance:_____ Claim number:_____

Case manager name: _____Contact details:_____

Usual GP's Name: _____

Clinic and suburb: _____

Usual Dentist's Name: _____

Clinic and suburb: _____

Are there any other medical practitioners you would like correspondence to be sent to?

Doctor's Name and Specialty: _____

Clinic and suburb: _____

Doctor's Name and Specialty: _____

Clinic and suburb: _____

CONSENT TO COLLECT PATIENT INFORMATION:

Your surgeon is a Medical Practitioner so full disclosure will ensure your best care.
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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. We will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating 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.

Patients Full Name: _____

Signature: _____ Date: _____

Parent or Guardian Full name (if applicable): _____

Signature: _____ Date: _____

MEDICAL HISTORY

Are you currently undergoing treatment with GP or specialist? YES / NO

If so, please explain briefly:

_____

Name of doctor and practice (*if different to regular GP*):

_____

Have you recently had the cold or flu? YES / NO

NOTE: If you have been admitted to any hospital outside WA / Australia within the last 12 months, please let our staff know.

PAST SURGICAL PROCEDURES

NONE ☐

Procedure	Year	Hospital

CURRENT MEDICATION

NONE ☐

Medication	Dose	Frequency

ALLERGIES

NONE ☐

Penicillin	
Pain killers *(e.g. codeine)*	
Latex	
Iodine	
Other *(please list)*	

Have you suffered from any of the below?

	YES	NO
Diabetes (Type 1 or gestational)		
Abnormal blood pressure (low / high)		
Blood disorder / prolonged bleeding / taking blood thinners (e.g. Warfarin / Aspirin)		
Cancer		
Liver disease (e.g. Jaundice / Hepatitis)		
Kidney disease		
Negative reaction to local / general anaesthetic (e.g. nausea post operation)		

Are you currently…

	YES	NO
Receiving treatment from a doctor, hospital or clinic?		
Have you had lap band / bariatric surgery?		
Taking any GLP-1 agonist medication (eg. Ozempic /Wegovy/ Mounjaro)?		
Having radiation therapy to head or neck?		
Receiving chemotherapy?		
Have you ever been on IV or Oral Bisphosphonates (used to prevent loss of bone mass, e.g. Prolia / Fosamax)?		
Taking the contraceptive pill?		
Pregnant or possibly pregnant?		
Breastfeeding?		
Having corticosteroid treatment (long term)?		

Is there any other information regarding your medical history that you would like us to know about?

_____

Do you smoke / vape? **YES / NO** If yes, how many per day? _____

Do you drink alcohol? **YES / NO** If yes how many units per day / week? _____

For anesthetic purposes, we need to know your weight and height:

Weight: _____ **Height:** _____

READ AND SIGN BELOW

I have been truthful and answered all questions to the best of my knowledge. I consent to the collection and use of the above information and all further information requested by and given to staff of Clinical A/Professor Dieter Gebauer during this and all subsequent consultations, to help and provide an accurate medical diagnosis and to facilitate treatment, including correspondence to my referring / family doctor.

Patient name: _____

Parent or Guardian name (if applicable) _____

Signature: _____ Date: _____