REGISTRATION FORM

Thank you for spending a few minutes to complete this form. Please bring this form with you to your consultation appointment. Please leave areas blank if the information is unavailable or unknown.

Mr/Mrs/Miss/Ms/Dr: .... Surname: .... Given Name/s: ....

Address: .... Postcode: ....

Home Phone: .... Work: .... Mobile: ....

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

Name of Next of Kin: .... Relationship: .... Phone No of Next of Kin: ....

Medicare No: .... Ref: .... Expiry Date: ....

("Ref": The reference number on your Medicare Card is the small number next to your name on the card).

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

Private Health Insurer: .... Private Health Membership No: .... Ref: ....

Level of Cover .... Employer: ....

Veteran's Affairs No (if applicable): .... Expiry Date .... TAC Claim #: ....

Workcover Insurer Name (if applicable): .... Claim #: ....

Local Doctor: .... Referring Doctor (if not Local Doctor): ....

Other Doctors who may be treating you: ....

Date of Injury: .... Nature/Location of Injury on the body: ....

Injury caused by: ....

Please tick YES or NO if any of the following are applicable to the condition for which you are attending this consultation:

MEDICAL PROBLEM	Yes	No	MEDICAL PROBLEM	Yes	No
Allergies to medicines, tapes, antiseptics or foods			Do you have cancer or a family history of cancer?		
Blood pressure problems			Do you have a pacemaker?		
Heart problems/murmurs			Hepatitis or liver diseases		
Excessive bleeding			Diabetes Type 1 ☐ Type 2 ☐		
Blood clots in the legs or lungs or a family history of this			Lung problems (shortness of breath, cough, wheeze, asthma, T.B., pneumonia)		
Stroke / fits / epilepsy			Kidney Disease		
Have you or a blood relative had a problem with an anaesthetic?			Do you smoke?		
			If yes, how many per day?		
Have you had a blood transfusion?			Are you pregnant?		

What tests or investigations have you had in the last six months relating to the current problem? Please list them:	What major operations have you had which may have a bearing on your current problem? Please list them:
List current & previous leisure/sporting pursuits:	List current medications (or attach a clearly written list).

I understand that payment of the account is my responsibility, and that my health fund/insurer may not cover the amount fully. I accept that if I default on my account, my details will be passed onto a collection agency.

Signature: .... Date: ....