Patient Registration

Please check and complete the following details

DR TIMOTHY YEOH
ORTHOPAEDIC SURGEON

Title First names Last name

Home phone Work phone DOB

Mobile phone ☐ Opt out of SMS Messaging

If we need to contact you and leave a message, may we use your ☐ Home ☐ Mobile ☐ Work ☐ Email

Email address

Street address

Postal address

Next of kin & Relationship Phone

Address

Treatment area

Family Doctor
(Name & address)

Physiotherapist
(Name & Address)

Occupation

Private Health Fund Membership number & Ref No

Medicare Ref No Expiry Veterans

☐ Are you making a claim for compensation?
- ☐ Workers' Compensation
- ☐ CTP
- ☐ Personal Injury Claim
- ☐ Public Liability
- ☐ Sports Insurance

Insurer

Date of injury

Claim Number

Address

Phone

Declaration

I have read the Privacy Amendment Act and give permission for correspondence to be sent to my referring doctor, general practitioner, physiotherapist and insurance company where appropriate.

I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.

Signed by patient or parent/guardian _____ Date _____

Name (Please print) _____

Please complete the Medical History Form on following page

Medical History

Name:……..

Do you suffer from any of the following (please circle):

Angina (chest pain)	Epilepsy	Thyroid disease
Heart attack	Kidney disease	HIV/AIDS
Heart disease	Asthma	Previous reactions to anaesthetic
Heart murmur	Emphysema/COPD	Bleeding disorders
High blood pressure	Liver disease	Clots in the lung (PE)
Diabetes	Hepatitis B or C	Clots in the leg (DVT)
Stroke/TIA	Stomach ulcers/reflux	Cancer

Have you ever smoked?	Yes/No	No per day:……..
Have you quit?	Yes/No	If so when:……
Do you drink alcohol?	Yes/No	Units per day:……
Have you ever taken intravenous drugs?	Yes/No	
Have you ever had possible contact with:	Hepatitis B or C? Yes/No	
	HIV Yes/No	
Could you be pregnant?	Yes/No	

Please list any previous operations:	Please list all medications:

Please list any allergies: ……

Specialty Orthopaedics

Consent to Collection of Personal Information

Collection of Personal Information, Privacy Act 1988 (Cth) and HRIP Act 2002 (NSW)

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 a full medical history so that we may properly assist, diagnose and treat illnesses and be pro-active in your health care. We will also 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
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of teaching. Please let us know if you do not want your records accessed for this purpose, and we will note your record accordingly
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to opt-out of any involvement

I have read the information above and 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 also aware that this practice has a privacy policy which contains information about accessing and seeking correction of personal information, privacy complaints handling process, and whether the practice is likely to disclose personal information to overseas recipients.

I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

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 that I notify this practice of:

Name

Signature

Date

Medical History

Name:……..

Do you suffer from any of the following (please circle):

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Have you ever taken intravenous drugs?	Yes/No	
Have you ever had possible contact with:	Hepatitis B or C? Yes/No	
	HIV Yes/No	
Could you be pregnant?	Yes/No	

Please list any previous operations:	Please list all medications:

Please list any allergies: ……