Dr Robert Creer

Patient Information Form

Date completed: ..... / / .....

Title:	Given Name:	Surname:	
Gender: ☐ M ☐ F	DOB: / /	Age:	
Address:		State	PCode
Postal address:		State	PCode
Ph(h):	Ph(w):	Mob:	☐ SMS reminders okay
Email:		Occupation:	
Medicare no:	Valid to: /	Ref no:	Pension no:
DVA repat no:	Service no:		Rank:
Referring Doctor:		Usual GP:	
Hospital Cover ☐ Y ☐ N	Private Health Fund:	Number:	Ref no:
Parent's name (or guardian if under 18):			Parent's DOB: / /
Emergency contact:	Relationship to you:		Ph:

Please note:

Your consultation is in the private rooms of a private clinic.

☐ I understand that full payment for consultation, plasters, bandages, splints, braces etc. is required at the time of consultation unless prior, documented arrangements have been made with this office. An account keeping fee for all outstanding accounts may be charged.

For private patients, an invoice/receipt, which can be taken to Medicare for rebate, will be issued with your payment. It is not the policy of this practice to bulk bill for services rendered. If you are having difficulties with payment please discuss this with Dr Creer's rooms prior to your appointment.

☐ I understand that I will only be notified by Dr Creer of any clinically relevant pathology results pertaining directly to my surgery.

☐ I give consent for medical information concerning myself or my child to be released to my insurer, employer, solicitor, my referring GP and other health professionals involved in my care.

☐ I give consent to the above information and any other relevant medical information being scanned and stored in my electronic patient file.

☐ I agree to the above conditions Signed: ..... Dated: ..... / / .....

Is This Consultation Related to a Medico-Legal Issue	☐ **Yes**	☐ **No**
Is This a Wokers Compensation or Third Party Claim **If yes please complete section below**	☐ **Yes**	☐ **No**

Written approval for consultation is required at the time of consultation otherwise fees will be the responsibility of the patient

Insurance Company:		
Address:		
Phone:	Fax:	Contact Person:
Claim no:	Date of injury:	
Employer (at time of injury):		
Employer Address:		
Phone:	Fax:	Contact Person:
Solicitor		
Address:		
Phone:	Fax:	Contact Person:

Dr Robert Creer

Medical History

Name: ..... DOB: / / Date completed: / /

Medical and Anaesthetic History *(Please circle your response)*		
Do you/or have you ever smoked?	Yes / No	If you have stopped, when did you quit?
Do you drink alcohol?	Yes / No	If yes, how many per week?

Past operation/s	**Name of Hospital**	**Year**

Have you or any relatives experienced problems with anaesthetic/s? *(including confusion)* If yes, please describe the problem/s:	Yes / No
Do you have any reason to believe you may be pregnant?	Yes / No

Do you suffer from any of the following medical illnesses? *(please tick)*

( ) High Blood Pressure	( ) Bleeding Disorders	( ) Stomach Ulcers / Reflux
( ) Heart Disease	( ) Leg Cramps	( ) Epilepsy
( ) Heart Attack	( ) Asthma / Airways Disease	( ) Liver Disease / Jaundice
( ) Angina / Chest Pain	( ) Bronchitis	( ) Hepatitis B or C
( ) Heart Murmur	( ) Diabetes	( ) HIV / AIDS
( ) Stroke / TIA	( ) Thyroid Disease	( ) Mental Health Issues
( ) Circulation Problems	( ) Renal / Kidney Problems	( ) Rheumatic Fever

Other:

Have you ever had blood clots? *(please tick)*

DVT ( ) legs ( ) lungs	**PE** ( ) legs ( ) lungs
If yes, when:	Treatment:
Has a member of your family ever suffered from blood clots in the legs or lungs?	Yes / No

Have you ever had a blood transfusion?

If yes, when: Any problem / reaction?	Yes / No
Have you had any possible contact with Hepatitis B?	Yes / No
HIV / AIDS virus?	Yes / No

Medication History *(please tick)*

Do you take any of the following?

( ) Aspirin	( ) Plavix	( ) Isocover
( ) Oral Contraceptive Pill	( ) Hormone Replacement Therapy	( ) Anti-arthritic medication
( ) Warfarin	( ) Heparin	( ) Clexane

Please list **all** current medications, including any over the counter preparations

Medication	**Dose / Frequency**	**Reason**

Allergies: medication / food / tape / latex

Allergy	Reaction

Please provide below any additional information you think is important for us to know: