Dr Rob Creer
Orthopaedic Surgeon
FRACS (Orth) FA Orth A

Dr Karen Bisley
Dr Warren McDonald
SPORTS PHYSICIANS ACT

PATIENT INFORMATION

Mr Mrs Miss Ms Master Dr Other_____ Gender:_____

Given Names:_____ Surname: _____

Known As: _____ Date of Birth:_____

Phone: (H) _____ (W) _____(M) _____

Email: _____

Street Address: _____

_____ Post Code: _____

Postal/Billing Address: (If different) _____

_____

Occupation: _____

Next of Kin: _____ Relationship: _____ Contact: _____

Family Doctor: _____

Doctor's Address: _____

Referring Doctor: (If different) _____

Physiotherapist: _____

Physiotherapist's Address: _____

Aged/Disability Pension Number _____

Private Health Fund: _____Number: _____

Medicare:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Position on card: ____ Expiry: ___/___

If patient is under 14 years old :

Parent name_____ D.O.B _____Medicare:_____

Veterans' Affairs No:_____ Expiry: _____

Military EP ID No: _____ Rank: _____

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MEDICAL HISTORY

Name: _____ Height: _____ cm Weight: _____ kg

What sports or physical activities do you participate in: _____

Do you suffer from any of the following medical illnesses?

High blood pressure	□	Heart Disease	□	Heart Attack	□
Angina / Chest Pain	□	Heart Murmur	□	Stroke / TIA	□
Circulation Problems	□	Bleeding disorders	□	Leg Cramps	□
Asthma / Airways Disease	□	Bronchitis	□	Diabetes	□
Thyroid Disease	□	Renal / Kidney Problems	□	Epilepsy	□
Stomach Ulcers / Reflux	□	Liver Disease / Jaundice	□	Hepatitis B or C	□
Mental Health Issues	□	Rheumatic Fever	□	Sleep apnoea	□
Blood Clots Leg / Lung	□	Family history of clots	□		
HIV / AIDS	□	Contact with HIV / AIDS or Hepatitis B	□		
Cancer _____		Other _____			

Have you ever had a blood transfusion If yes, when _____ Any problems / reactions _____

_____

Do you take any of the following:

Aspirin □ Oral Contraceptive Pill / Implant □ Hormone Replacement □

Anti-arthritic Medication □ Anti-coagulants YES □ / NO □ Plavix □ Xeralto □ Isocover □

Warfarin □ Heparin □ Clexane □

Current medications including non-prescription:

_____ _____

_____ _____

_____ _____

Current allergies:

_____ _____

_____ _____

Past operations:

_____ _____

_____ _____

_____ _____

_____ _____

Have you previously had any anaesthetic problems: YES □ / NO □

Have you been told you have a difficult airway: YES □ / NO □

Do you smoke : YES □ / NO □

Do you drink alcohol YES □ / NO □ drinks per week _____

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

_____

_____

_____

If under 18 Parent/Guardian Responsible for Account: _____

Your consultation is in the private rooms of a private clinic

□ I understand that full payment for consultation and consumables is required at the time of consultation unless prior documented arrangements have been made with this office.

□ 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 the staff prior to your appointment.

□ I understand that I will only be notified by the doctor of any clinically relevant pathology results pertaining directly to my surgery/reason for visit.

□ 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.

SIGNED: _____ DATE: _____

NAME OF PATIENT/PARENT/GUARDIAN: _____

Is this, or may this be, a Workers Compensation injury YES □ / NO □ If yes, please continue on next page

WORKERS COMPENSATION

Date of Injury: _____

Claim Number: _____

Insurance Company: _____

Insurance Company Address: _____

Case Manager: _____

Case Manager's Phone: _____

Case Manager's Fax: _____

Name of Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

I have provided the above information to the best of my knowledge and understand that I will be personally responsible for the payment of all medical fees should the cost not be approved by my insurer.

SIGNED: _____ **DATE:** _____