Confidential Patient Registration Form – Mr. Keith Mutimer

Surname: Mr./Mrs./Ms./Miss: Given Names:

Address:

Person Responsible for the Account:

Date of Birth: Age: Occupation:

Telephone: Home: Business:
Mobile: **Email address:**
Are we able to SMS for appointment confirmation Yes / No

Next of Kin: Contact Telephone Number:

Health Insurance Fund: Membership No.: Veterans Affairs No

Medicare No: Ten digits: Your Ref No. Expiry Date: ...../20.....

Name of your local doctor: Telephone:

Are you a Torres Strait Islander/Aboriginal? Yes/No

Country of Birth

General Health History

Do you have any medical problems (please circle if yes): blood clot in the legs, blood clots in the lungs, diabetes, asthma, hepatitis, HIV or AIDS exposure, high blood pressure, heart attack, angina, rheumatic fever, epilepsy or psychiatric treatment, heart disease, heart attack, heart rhythm problems, palpitations, stroke, diabetes
If other, please state:

Are you taking any medications or drugs (please circle if yes): anti-inflammatory drugs, pain-killers, birth control pill, cortisone, anti-depressants, and tranquillisers?
If other, please state:

Are you taking medication at present (eg. Aspirin, Disprin, Warfarin or Vitamins, Blood Pressure tablets)? Yes/No
If yes, please state:

Are you allergic to any medicines or tapes? Yes/No

Have you had any operations in the past (including cosmetic surgery)? Yes/No
Please explain including dates and indicate any complications:

Have you had any problems with anaesthetics in the past? Yes/No

Have you ever had any past or family history of bleeding problems? Yes/No

Do you see any specialists, name of specialist and phone number Yes/No ……

Do you regularly drink alcohol? If yes, how much alcohol do you consume per day? ……..

Do you smoke, if yes, how many per day ……

How did you hear about Mr. Mutimer:

Signed: **Date:**

It is imperative that you complete each box of this form for medical reasons