PATIENT INFORMATION & CONSENT FORM

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Surname: Given Names:

Date of Birth: / / Known as:

Residential Address: Home Ph:

Work Ph:

Suburb: Postcode: Mobile:

Postal Address: Email:

I consent to receving reminders & notifications via SMS Yes ☐ No ☐
I consent to receving reminders & notifications via EMAIL Yes ☐ No ☐
I consent to receving a patient survey via EMAIL Yes ☐ No ☐

Medicare Number: Ref No [next to your name]: Expiry: /

If Patient under 18 Parent/Guardian Name: DOB: Ref No:

DVA Number: Gold ☐ White ☐ Disability:

Pension/Health Care Number: Expiry: / /

Private Health Fund Name: Hospital Cover: Yes ☐ No ☐

Private Health Fund Number:

Is your treatment covered under Workcover / Third Party Insurer: Yes*** ☐ No ☐

******Complete claim form provided***

Usual General Practioner: [Must be completed] Suburb/Clinic:

Referring Doctor: [Must be completed] Suburb/Clinic:

Next of Kin Name: Phone: Relationship:

Nominated Contact Person: **I GIVE / DO NOT GIVE** my consent for the nominated family member and/or friend to communicate on my behalf with the practice about my medical care/treatment

Nominated Person Name: Phone: Relationship:

Your Information and Privacy Disclosure

- *Your consent is required for this practice to collect/store your personal and health information, as well as to disclose information to others involved in your health care management, including treating doctors and specialists, allied health professionals outside this practice, Work Cover, Medicare and any disclosure of the medical tests or reports that are relevant to your ongoing treatment.*
- *No access to your medical records will be provided to any other unauthorised person or organisation i.e. solicitor, insurance companies etc. without your express written consent.*
- *I understand that I am responsible for full payment of today's consultation fee as a private patient along with any subsequent review appointment fee (not applicable to Work cover or Third party patients, where payment has already been pre-approved/authorised)*
- *This practice, by necessity, collects personal and intimate details about its patients. Often patient's relatives and/or friends call to enquire about patient's wellbeing or to offer assistance in the patient's care*

Patient / Guardian Signature Date: / / **Please complete pg 2**

PAST MEDICAL HISTORY *– I acknowledge the below information is true and correct to the best of my knowledge.*		
CONDITION	**Please Tick Box Below**	**DETAILS**
Heart/Vascular System	Y ☐ N ☐	
Lungs	Y ☐ N ☐	
Digestive	Y ☐ N ☐	
Urinary	Y ☐ N ☐	
DVT/Pulmonary Embolus	Y ☐ N ☐	
Specific ongoing joints, muscles or bone issues	Y ☐ N ☐	
Brain/Nervous	Y ☐ N ☐	
Previous Hospitalisation/surgeries	Y ☐ N ☐	
Diabetes	Y ☐ N ☐	
Are you a smoker ? If so... How many cigarettes per day ?	Y ☐ N ☐	

MEDICATIONS: *Are you taking any of the following?*			
APIXABAN [Eliquis]	Y ☐ N ☐	RIVAROXABAN [Xarelto]	Y ☐ N ☐
CLOPIDOGREL [Plavic / Iscover]	Y ☐ N ☐	WARFARIN	Y ☐ N ☐
ASPIRIN	Y ☐ N ☐	BRILINTA	Y ☐ N ☐
FISH OIL	Y ☐ N ☐	TURMERIC	Y ☐ N ☐
JARDIANCE	Y ☐ N ☐	JARDIAMET	Y ☐ N ☐
GLYXAMBI	Y ☐ N ☐	FORXIGA	Y ☐ N ☐
QTERN	Y ☐ N ☐	XIGDUO	Y ☐ N ☐
STEGLATRO	Y ☐ N ☐	STEJLUJAN	Y ☐ N ☐
SEGLUROMET	Y ☐ N ☐	AS PER REFERRAL	Y ☐ N ☐
OTHER: Please list…			

Family Medical History:

Allergies:

Do you have religious beliefs that affect the use of a blood product? Yes ☐ No ☐

Occupation: Dominant Hand: Right ☐ Left ☐ AGE:

How did you hear about Dr Graze?