DR DAVID PARKER **PATIENT INFORMATION SHEET**

Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Master ◯ Dr ◯ **Given Name/s:**		**Surname:**	
Address:			
		postcode:	

Date of Birth:		**Country of Birth:**	

Contact Details:		**home**	**work**	**mobile**
	Patient:			
Next of Kin: Name	**Relationship to Patient**			

Occupation:		**Employer / School:**	
email address:			

Medicare No:		Ref: (line no.)		**Expiry date:**	
PRIVATE Health Fund:		**Membership No:**			
Private Hospital Cover ?	**yes** ◯ **no** ◯	**served qualifying period?**	**yes** ◯	**no** ◯	

Dept Veterans Affairs:	**DVA NO:**	☐ **DVA GOLD CARD** ☐ **DVA WHITE CARD**

Referring Doctor:		**Suburb:**	
Local / Family Doctor:		**Suburb:**	
Treating Physiotherapist:		**Suburb:**	

Is your knee problem injury related? **yes** ◯ **no** ◯	**How did it happen?**
Indicate your main concerns and/or restrictions with this knee:	☐ **swelling** ☐ **pain** ☐ **reduced mobility** ☐ **reduced range of motion** ☐ **other:**
Other Medical Conditions:	
Medications: (list all current)	
Allergies:	
Previous Surgeries : (list all)	
Anaesthetic problems: (list personal and/or family problems)	

LIFESTYLE	**Smoking (cigarettes etc. per day average):**	
	Alcohol (beer, wine, liquor average per week):	
	Sports Involvement:	

WORKERS COMPENSATION / THIRD PARTY (if applicable)		**Injury Date:**	
Insurance Company:			
Contact Name:		**Claim Nbr:**	

☐ **I have been given the information sheet on confirming appointments for this practice (see next page, blue sheet)**

☐ **I choose to receive SMS reminders & will reply Y to confirm appointments, OR** ☐ **I will phone to confirm appointments**

I have read the PRIVACY ACT CONSENT FORM (next page) regarding the handling of my information by this Practice for the purposes set out in that form. I consent to the handling of that information subject to any limitations on access or disclosure about which I notify this Practice.

Signed: …… Date: ……..

Patient Name: ……Guardian/Parent: ……..……..……..