SydneyShoulder Specialists

Dr Allan Young
New Shoulder Patient Details

Patient Information

Your title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other: ____________________

First (given) names*: ____________________ Surname*: ____________________

***must** be the same as they appear on your Medicare card if you have one

Preferred Name (if any): ____________________ **Date of Birth**: __________ Male ☐ Female ☐

Address: ____

State: __________ Postcode: __________

Mobile: __________ Home Telephone: __________ Email: ____________________

Medicare Number: ____________________ Your Ref No on the card: __________

Private Health Fund: ____________________ Membership No: __________

DVA Card Number: ____________________ Gold ☐ or a White ☐

Name of referring doctor: ____________________ Is this doctor is a: GP ☐ or a Specialist ☐?

The name of your usual GP (general practitioner) if different from above: ____________________

GP's address: ____________________ Phone: __________

Email: ____________________ Fax: __________

Physiotherapist: ____________________ Phone: __________

Physiotherapist's address: ____

Email: ____________________ Fax: __________

What is (or was) your occupation? ____________________

Will your consultation be related to a claim for Workers Compensation? YES ☐ NO ☐? *If you answered **YES**, please complete:*

Workers Compensation Claims ONLY

Date of Injury: ____________________ Claim Number: ____________________

Insurance Company: ____

Insurance Company's address: ____________________ Fax: __________

Case Manager's name: ____________________ Phone: __________

Case Manager's email address: ____

____

Australian Defence Force Members ONLY

Rank: ____________________ Service Number: ____________________

Stationed at: ____

Which Shoulder?

Which shoulder is it? Left ☐ Right ☐ *or* both ☐

Which hand do you write with? Left ☐ Right ☐ *or* ambidextrous ☐

Next of Kin

Next of kin: ____________________ (**required by law**) Next of kin's mobile number: __________

What is your next of kin's relationship to you? ____________________

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Medical History

Arthritis

Rheumatoid Arthritis No ☐ Yes ☐

Diabetes No ☐ Yes ☐

Epilepsy No ☐ Yes ☐

Liver Disease

Hepatitis B No ☐ Yes ☐

Hepatitis C No ☐ Yes ☐

Stroke(s) No ☐ Yes ☐

HIV/AIDS No ☐ Yes ☐

Kidney Conditions No ☐ Yes ☐

Gastric Problems

Indigestion/Reflux No ☐ Yes ☐

Stomach Ulcers No ☐ Yes ☐

Cardiac Conditions

Heart attack No ☐ Yes ☐

High blood pressure No ☐ Yes ☐

Other: ____________________

Lung Conditions

Asthma No ☐ Yes ☐

Emphysema No ☐ Yes ☐

Sleep Aponea No ☐ Yes ☐

Pulmonary Embolus No ☐ Yes ☐

Are you a smoker? Never Quit ☐ Yes ☐

Cancer

Breast No ☐ Yes ☐

Mastectomy No ☐ Yes ☐

Other: ____________________

Venous Conditions

DVT (Thrombosis) No ☐ Yes ☐

Allergies

Do you have any **allergies to DRUGS**? No ☐ Yes☐ If yes, which drugs? ____________________

____

Medications

Do you take **blood thinners**? No ☐ Yes☐ If yes, name of medication: ____________________

Are you **diabetic**? No ☐ Yes☐ Type 1 ☐/Type 2 ☐ If yes, name of medication: ____________________

Please list any other medications that you currently take: ____________________

____

Please list any other significant medical/surgical history: ____________________

____

____

Have you ever had complications after surgery? E.g. infection, DVT, problem with anaesthesia, etc.: ____________________

____

Consent to Collect Patient Information – Privacy Act 2002

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. **NB:** please refer to our practice *Privacy Policy* online at www.sydneyshoulder.com.au or ask for a copy. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice;
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements; and
3. Disclosure to others involved in your care, including doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any purpose other than the above, my consent will be sought. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

I further understand that I am seeking the care of Dr Young for my medical management and that it is a policy of the practice that Dr Young **does not** undertake examinations and/or reports for the purpose of Medico-Legal matters or Third Party claims.

Signed (*a digital signature is accepted*): ____________________ **Date:** ____________________

Name (*typed or printed*): ____________________ Email completed form to reception@sydneyshoulder.com.au.

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