HARBOUR SPINE SURGEONS

REGISTRATION FORM

TITLE	FULL NAME	D.O.B / /

ADDRESS

PHONE	MOB	EMAIL

NEXT OF KIN

FULL NAME	RELATIONSHIP

ADDRESS

PHONE	EMAIL

GENERAL PRACTITIONER

FULL NAME	PHONE

ADDRESS

PHYSIOTHERAPIST/CHIROPRACTOR

FULL NAME	PHONE

ADDRESS

INSURANCE INFORMATION (AS APPLICABLE)

MEDICARE NUMBER					—						—		EXPIRY /

MEDICARE CARD INDIVIDUAL REFERENCE NUMBER	

PRIVATE HEALTH FUND	MEMBERSHIP NUMBER

DEPARTMENT OF VETERAN AFFAIRS NUMBER

WORK COVER INSURER	CLAIM NUMBER

WORK COVER CASE MANAGER

CURRENT PROBLEM

WHAT IS THE MAIN PROBLEM YOU ARE SEEKING TREATMENT FOR?

HOW LONG HAVE YOU HAD THESE SYMPTOMS?

WHAT TREATMENT HAVE YOU HAD SO FAR?

PAST MEDICAL HISTORY

			SPECIFY
HEART DISEASE	◯ YES	◯ NO	
PACEMAKER	◯ YES	◯ NO	
DIABETES	◯ YES	◯ NO	
HIGH BLOOD PRESSURE	◯ YES	◯ NO	
CHOLESTEROL	◯ YES	◯ NO	
ASTHMA	◯ YES	◯ NO	
LUNG DISEASE	◯ YES	◯ NO	
DEEP VEIN THROMBOSIS	◯ YES	◯ NO	
PULMONARY EMBOLUS	◯ YES	◯ NO	
KIDNEY DISEASE	◯ YES	◯ NO	
STROKE	◯ YES	◯ NO	
EPILEPSY	◯ YES	◯ NO	
PARKINSONS DISEASE	◯ YES	◯ NO	
CANCER	◯ YES	◯ NO	
BLOOD DISORDERS	◯ YES	◯ NO	
OSTEOPOROSIS	◯ YES	◯ NO	
RHEUMATOID ARTHRITIS	◯ YES	◯ NO	
PREVIOUS ANAESTHETIC COMPLICATIONS	◯ YES	◯ NO	

OTHER

PAST SURGICAL HISTORY

YEAR	SURGERY

MEDICATIONS

DO YOU TAKE FISH OIL, KRILL OIL, OR ANY KIND OF HERBAL MEDICATION? ◯ YES ◯ NO

ARE YOU ON THE ORAL CONTRACEPTIVE PILL (OCP) OR HORMONE REPLACEMENT THERAPY (HRT) ◯ YES ◯ NO

DRUG ALLERGIES

SOCIAL HISTORY

WHAT IS YOUR PRESENT OCCUPATION?
WHO LIVES WITH YOU?
HOW MUCH ALCOHOL DO YOU DRINK?
DO YOU SMOKE TOBACCO?

CONSENT TO COLLECT PERSONAL INFORMATION (PRIVACY ACT 1988)

Harbour Spine Surgeons (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 a full medical history so that we may properly assess, diagnose and treat illness. We will also use the information you provide in the following ways:

- Disclosure to others involved in your health care, including treating doctors, specialists and allied health practitioners outside Harbour Spine Surgeons. This may occur through referral to other doctors, referral for tests and in the reports communicated between us and others involved in your health care.
- Disclosure to other doctors, locums and registrars attached to Harbour Spine Surgeons for the purpose of patient care and teaching.
- Disclosure for quality assurance activities to improve individual and community health care.
- Administrative purposes in operating Harbour Spine Surgeons.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

I am aware that Harbour Spine Surgeons has a privacy policy on handling patient information, which can be provided upon request.

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 given to me.

I am aware of my right to access the information collected about me, except in limited circumstances where access might legitimately be withheld. I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by Harbour Spine Surgeons for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

NAME	**SIGNATURE**
DATE / /	