Dr Warren Kuo
Orthopaedic Surgeon MBBS FRACS FAOA t 02 4732 4557 e info@orthokuo.com

PATIENT INFORMATION SHEET

ALL FEES ARE PAYABLE AT TIME OF CONSULTATION

(Please circle or fill in as required)

Mr/Ms/Mrs/Miss/Dr/Other:_____ **First Name:**_____

Middle Name(s): _____ **SURNAME:**_____

Gender: Male / Female Date of Birth: (DD/MM/YYYY):_____

Residential Address:_____

_____ **State:** _____ **Postcode:** _____

Postal Address:_____

Telephone Home:_____ **Work:**_____ **Mobile:**_____

Email:_____

Occupation _____ **RETIRED: YES / NO Marital Status:**_____

Medicare No:_____ **Patient No :**__ **Expiry:** _____

Age Pension:_____ **DVA No:**_____ **DVA: Gold Card / White Card**

Private Health Insurance Fund Name: _____ **Membership No:**_____

General Practitioner Name:_____ **Suburb:**_____

Have you received treatment from Dr Kuo previously? YES / NO

SPORTS: (Playing or Played)_____

NEXT OF KIN:

Name:_____ **Relationship:**_____ **Tel:**_____

Is this a Workers' Compensation or Third Party Claim? Please indicate: WC / TP / Neither

Employer:_____ **Date of Injury:**_____

Address:_____ **Telephone:**_____

Insurance Company:_____ **Claim Number:**_____

Address:_____

Phone:_____ **Fax:**_____ **Case Manager:**_____

Solicitor:_____

Address:_____ **Phone:**_____

The patient confirms these details are correct and undertakes to pay all fees owing to Dr Kuo in the event of liability being denied by the insurance company.

SIGNED:_____ **DATE:**_____

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Dear Patient,

Re: COLLECTION OF PERSONAL INFORMATION, PRIVACY ACT 1988

We require your consent to collect personal information about you. 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 illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

- Correspondence will usually be sent to the Referring Doctor, GP and physiotherapist as required.
- In the case of a Workers' Compensation or Third Party claim, personal/medical details may also be released to either the insurance company and its representatives and/or your Solicitor.
- Administrative & Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating Doctors and Specialists outside this medical practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.

If the practice undertakes training of students, or research activities, then the following clauses may be adopted:

- Disclosure to other Doctors in the practice, Locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note it on your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. 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 I request access to information about me, the practice will be entitled to charge me fees to cover:

- time spent by administrative staff to provide access at the employee's hourly rate of pay plus 20%,
- time necessarily spent by a medical practitioner to provide access at the practitioner's ordinary sessional rate
- photocopying and other disbursements at cost

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

ACCOUNT/PAYMENT AGREEMENT:

Any accounts that may be given for services rendered by Dr Warren Kuo must be paid within 4 weeks of the date of service. Any accounts that remain unpaid greater than 4 weeks from the date of service may be forwarded to a debt collector. By signing below you are agreeing to all necessary measures to be taken in recovery of the debt. If we incur any costs of collection, such as legal fees and collection agency fees etc., you agree to indemnify us for all such costs.

PATIENT NAME (Please print):_____

Signed:..... Date:.....

Medical History Questionnaire

NAME:_____ **DOB:**_____ **HEIGHT:**_____ CM **WEIGHT:**_____KG

Do you drink alcohol? Y/N How many per week? _____ **Do you smoke? Y/N** How many per day?_____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?	**NO**	**YES**	**DETAILS**
Diabetes: □ Type 1 □ Type 2 □ Unsure			Managed by: □ Diet □ Tablets □ Insulin
Cancer			Site:
Radiation/Chemotherapy			Date of last treatment:
Stroke			Date:
Asthma/Breathing Issues			
High Blood Pressure / Low Blood Pressure			
Heart Attack/Coronary Stents			Details:
Pacemaker or **Any Other Heart Condition**			Specify:
Blood Clots, DVT or Bleeding Disorder			Details:
Arthritis – Rheumatoid or Osteo			
Thyroid Problems			
Liver Disease / Hepatitis			Type: □ A □ B □ C
Kidney/Bladder problems			
Gastrointestinal Ulcers/ Reflux/ Hiatus Hernia			Specify:
Epilepsy/ Fits/ Blackouts			Specify:
Depression or Other Mental Illness			
Migraines or Severe Head Pain			
Sleep Apnoea			
Fibromyalgia			
Tuberculosis			Date:
AIDS or HIV			
MRSA or VRE			Date:
ALLERGIES	**NO**	**YES**	**DETAILS**
Do you have any allergies to medications, food or other substances? (eg. Penicillin, tree nuts, latex/sticky plaster)			Allergy & Reaction:
MEDICATION	**NO**	**YES**	**DETAILS**
Do you take any steroids, anti-inflammatory medication or Cortisone tablets/injections?			Name of drug & how often taken:
Do you take any blood-thinning medication? (eg. Plavix, Aspirin, Warfarin)			Name of drug & who prescribed them for you:
Do you take medication for diabetes?			Name of drug:

Are you under the care of any other Specialist? Please list the Doctors name and condition you are being treated for.

_____ ___ _____

_____ _____

_____ _____

Are you on any medication? Please list below.

_____ _____ _____

_____ _____ _____

_____ _____ _____