COASTAL ORTHOPAEDICS AND SPORTS INJURIES
PATIENT INFORMATION

COASTAL ORTHOPAEDICS AND SPORTS INJURIES

Coastal Orthopaedics and Sports Injuries is committed to providing the best possible care to our patients. To assist us with this it is important to have the most accurate information possible. Please fill in ***ALL*** of the questions carefully. As a patient at Coastal Orthopaedics your personal information is treated with privacy and confidentiality and only provided to people assisting in your care.

Mr Mrs Ms Miss	Surname:	Given Names:	Date of Birth:
Address:			
Parents Names & Date of Birth: (if patient under 18 years old)			
Home Phone:	Work Phone:	Mobile:	
Email address:			
Occupation:	Marital Status:		
Medicare Number: _ _ _ _ _ _ _ _ _ _ Ref # _ Expiry: _ _ /20_ _			
Does Medicare have your bank details: Yes ☐ No ☐			
DVA Number:	Gold / White (please circle)		
Aged Pension Number:			
Private Health Insurance? Yes ☐ No ☐ **Name of Health Fund:**	**Membership Number**:		
Referring Doctor: (Doctor referring you)	**Local GP:** (Your usual Doctor)		
How did you hear about Coastal Orthopaedics? Friend ☐ GP ☐ Therapist ☐ Other:			
WORKERS COMPENSATION / THIRD PARTY ***Please complete all the following information if you are making a Claim***			
Employers Name:			
Employers Address:			
Insurance Company Name:			
Date of Injury:	**Claim Number:**		
Insurance Company **Postal** Address:			
Case Manager:			
Insurers Email Address:	Phone Number:	Fax Number:	
Solicitor's Name::			
Solicitor's Address:			
Solicitor's Email Address:	Phone Number:	Fax Number:	
I hereby authorise Coastal Orthopaedics to forward to my Employer/ Insurance Company/ Solicitor/ Rehabilitation Provider any necessary particulars and/or reports. Signed: _____ Date: _____			

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MEDICAL HISTORY

Please answer **ALL** of the following questions carefully

Do you have any known allergies: Yes ☐No ☐	If yes what?
Non Smoker ☐ Current Smoker ☐ Ex-Smoker ☐	Number of Cigarettes per day:
Do you drink alcohol? Yes ☐No ☐	Number of glasses per week:
Do you any problems with anaesthetics? Yes ☐No ☐	If yes, what?
Prior blood transfusions? Yes ☐No ☐	
Prior blood clots in your legs or lungs? Yes ☐No ☐	
Prior stomach ulcers? Yes ☐No ☐	
Have you had any possible contact with: Hepatitis A,B,C or HIV Virus Yes ☐No ☐	

MEDICATIONS

Please list all Medications

MEDICAL CONDITIONS

Do you suffer from any of the following Medical Conditions:

CONDITION	**OTHER CONDITIONS:** Yes ☐No ☐
High Blood Pressure: Yes ☐No ☐	
Cardiac Problems: Yes ☐No ☐	
Diabetes: Yes ☐No ☐ Type I ☐ Type II ☐	
Respiratory Problems: Yes ☐No ☐	

PAST OPERATIONS

Please list all past operations

OPERATION	**YEAR**	**SPECIALIST**

EMERGENCY CONTACT PERSON

Emergency Contact Name:	
Relationship to you:	Phone:

Consent Declaration:

I, _____ hereby consent to Coastal Orthopaedics and Sports Injuries obtaining information regarding my health care from other health care professionals involved in my care.
I further give my permission for Coastal Orthopaedics and Sports Injuries to transfer information to my regular general practitioner and allied health professionals.

Signature: _____ Date: _____

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CONSENT FORM –

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

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, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Health Insurance Commission requirements and Debt Recovery Services.
- Disclosure to others involved in your health care and/or claim. This may include, treating doctors, specialists, allied health care personnel outside this medical practice and any third party that is involved with your case such as Solicitors or Insurance Companies. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals.
- 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.

PRIVACY CONSENT

I give permission for the following person/s to make enquires on my behalf regarding appointments and my medical condition:

Name:	Date of Birth:	Relationship:

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 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.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Initial Consultation Questionnaire

(Please fill in before consultation and bring on day of consultation)

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Email Address: _____

Presenting Problem: _____

Date of Onset or Injury: _____

Date of Initial Visit with Dr Bateman: _____

Types of investigations (i.e. Xray, Ultrasound): _____

Previous Management (Injection Dates, Physio's name): _____

For Upper Limb Problems:

Which is you're dominate side: (left, right or ambidextrous): _____

Is your dominant side the affected side: _____

Is your non-dominant side (Please circle)

Normal, near normal, abnormal, severely abnormal **For All Conditions:**

Were the Onset of Symptoms: **Gradual / S udden**

Cause of Symptoms: **Sport, Car/Motor Bike Accident, Other Accident, Unknown**

Work Related Injury: _____

Any Major Medical Issues: _____

Do you take blood thinning medication: _____

Have you had any problems with anaesthetics: _____

Do you have any allergies: _____

Do you have a history of any major infections or blood clots: _____

What are your goals of the consultation: _____

All correspondence to: Locked Bag 39, Gosford NSW 2250
www.cosi.com.au

Coastal Orthopaedics and Sports Injuries

John Morton
Orthopaedic Surgeon

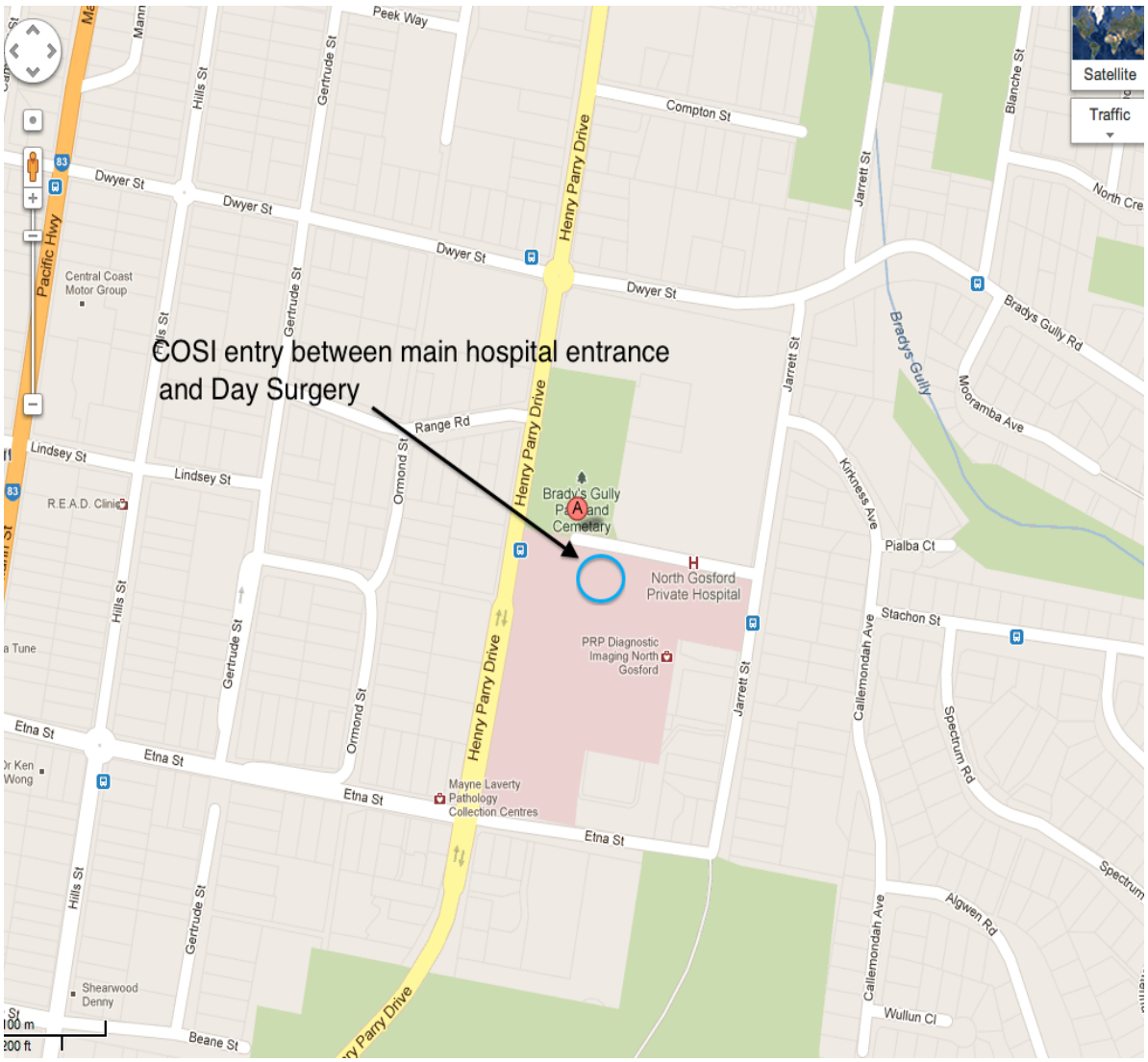
Michael Hunter
Orthopaedic Surgeon

Stuart Gray
Orthopaedic Surgeon

Ed Bateman
Orthopaedic Surgeon

Steve Marchalleck
Orthopaedic Surgeon

Coastal Orthopaedics and Sports Injuries



We are located at Gosford Private Hospital between the

Main Entrance and Day Surgery Unit.