ALLEN CHONG
Orthopaedic Surgeon
GENERAL ORTHOPAEDIC SURGERY
Arthroscopic Surgery

NEW PATIENT INFORMATION

Surname: ______________________________ **Mr/Mrs/Miss/Ms** (please circle)

First Name: ______________________________ **Second Name:** ______________________________

Known Name: ______________________________ **Date of Birth:** ________/________/________

Mailing Address: ____

____ **Post Code:** ______________

Telephone: **(H)**_______________ **(W)**_______________ **(M)**_______________

Occupation: ____

Next of kin: ______________________________________ **Relationship:** ______________

Contact: **(H)**_______________ **(W)**_______________ **(M)**_______________

Doctor referring you to Mr Chong: ____

Family doctor (if not the same as above): ____

Do you have private health insurance? **Yes / No** (please circle)

If yes, name of Insurer: ______________________________

Does this cover for in-hospital stays? ______________________________

Membership Number: ______________________________

Medicare Number: ______________________________ **Patient Reference Number**______

Expiry______________________________

Concession Card Number: ______________________________ **Expiry**______/______/________

DVA Number: ______________________________

Is this appointment for a WORKERS COMPENSATION OR MOTOR VEHICLE INJURY CLAIM? **Yes / No**

Name of person responsible for account: ____

TERMS AND CONDITIONS OF ACCOUNTS FOR DOCTOR ALLEN CHONG

Other than in a Workers' Compensation or Motor Vehicle Insurance situation, patients seen by Doctor Allen Chong are considered to be responsible for their own accounts. If a valid claim number is not supplied at the time of consultation, you will be held responsible for all subsequent fees and charges.

Accounts relating to appointments within the consultation rooms are required to be paid on the day of the appointment.

Private accounts payable, relating to operations in hospital are required to be paid in full, prior to surgery. If the account is not able to be paid within this period, it is the patient's responsibility to notify the Accounts Manager at Bunbury Orthopaedic & Sports Surgery and make alternative arrangements.

PATIENT DECLARATION:

I, ____, declare that I understand the above information and that I agree to abide by these terms and conditions.
PATIENT'S SIGNATURE: ____DATE: _______/_______/_______

For Office Use Only **For Office Use Only** **For Office Use Only**

R ☐
D ☐

INJECTION	DATE
____________	____________
____________	____________
____________	____________

PLEASE TURN OVER

HEALTH QUESTIONNAIRE

PAST ILLNESSES OR OPERATIONS:

Illness or surgery	Year	Illness or surgery	Year

LIST OF MEDICATIONS: (tablets, injections, medicines, patches, puffers, eye drops etc.)

Medication	Dose	Medication	Dose

1. **ARE YOU ALLERGIC TO ANY MEDICINE?** Yes / No
   If yes, what are they and what reaction do you have?
   ____
   ____

2. **HAVE YOU OR ANY RELATIVE HAD ANY PROBLEMS WITH AN ANAESTHETIC?** Yes / No
   ____
   ____

3. **HAVE YOU EVER HAD ANY HEART OR BLOOD PRESSURE PROBLEMS?** Yes / No
   (Circle problems) high blood pressure, chest pain, angina, heart attack, rheumatic heart, heart murmur, pacemaker, other: ____

4. **DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:**

   Insulin or Non Insulin Diabetes? Yes / No
   Blood clots or bleeding problems? Yes / No
   Are you on any blood thinning medications (eg Warfarin, Aspirin)? Yes / No
   Kidney condition? Yes / No
   Heartburn or acid reflux? Yes / No
   Hepatitis or liver problems? Yes / No
   Epilepsy, blackouts or stroke? Yes / No
   Asthma or any breathing problems? Yes / No
   Do you have a gastric band? Yes / No

5. **HAVE YOU EVER BEEN A SMOKER?** Yes / No

6. **Weight**__________________ **Height**________________

Any information in this questionnaire remains strictly confidential.