



NEW PATIENT INFORMATION

Surname: _____ Mr _____ Mrs _____ Miss _____ Ms _____

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

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

R	<input type="checkbox"/>
D	<input type="checkbox"/>

For Office Use Only

INJECTION	DATE
_____	_____
_____	_____
_____	_____

For Office Use Only

PLEASE CONTINUE BELOW

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.