

NEW PATIENT FORM

Welcome. To assist us with patient records, please fill in the following questionnaire:

Contact Details

Title: Mr / Mrs / Dr / Ms / Miss

Surname: **First Name:**

Address: **Suburb:** **Postcode:**

Postal address if different to above:

Telephone: Home: Work: Mobile:

Email:

Date of birth: / / **Current Age:**

Do you have Private Health Insurance? YES / NO **Fund Name:**

Member number: **Number of Years in Fund:**

Medicare card number: _ _ _ _ _ REF No: **Valid to:** /

Veterans Affairs Care Card Number: **Colour of DVA Card:**

Next of kin: **Mobile:**

Name of Referring Doctor:

Name & Address of Family Doctor (If different to referring doctor):

Medical History

Have you previously been hospitalised: YES / NO: **If YES, what was the condition or procedure:**

Do you have any medical problems (e.g. high blood pressure, vascular disorder, respiratory trouble, asthma, bleeding disorder, blood clots, hepatitis, stomach ulcers, diabetes, other)?

YES / NO: If YES, details:

Regular Medications:

Allergies:

Do you smoke? YES / NO: If YES, how many per day:

Who initially recommended you see Mr Howells? (Please circle) GP / Physio / Family / Friend / Other:

INFORMATION ABOUT FEES AND PRACTICE POLICY

The cost of a consultation is above the Medicare schedule fee. This means you will not recover the full fee after claiming from Medicare. Accounts are payable at the time of consultation. There maybe additional charges for procedures undertaken (i.e Injection/plaster etc.)

Any unpaid accounts for consultation or surgery will be sent to our debt collectors and you will be responsible for all fees incurred.

I have read the above and agree to abide by the payment terms of this practice. I consent to all or any of the above information to be released to other health providers and agencies during the course of my treatment.

Patient Signature:

Date: / /

Thank you.