



Adult & Paediatric Ear, Nose and Throat Surgeons

# Confidential Patient Registration Form

Mr  Mrs  Ms  Miss  Dr  Master

Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Email: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (M): \_\_\_\_\_

Medicare No: \_\_\_\_\_ REF No\*: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

**If the patient is a child under the age of 18, please provide details of one parent or caregiver that is listed on the same**

**Medicare card**

Parents Full Name : \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medicare No: \_\_\_\_\_ REF No\*: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Pension No: \_\_\_\_\_

Veterans Affairs No: \_\_\_\_\_  Gold  White

Do you have private health insurance?  Yes  No Does this cover hospital admission?  Yes  No

Have you been a member for more than 12 months?  Yes  No If answered **NO**, please advise start date: \_\_\_\_\_

Private health fund: \_\_\_\_\_ Membership No: \_\_\_\_\_

Emergency contact / next of kin: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you give permission to discuss your details with the above?  Yes  No

Usual family doctor name (if different Practice from referring doctor): \_\_\_\_\_

GP Address: \_\_\_\_\_ Suburb: \_\_\_\_\_

**Patient consent to collect and disclose information:**

This practice collects information from you for the primary purpose of providing quality health care, to properly advise and treat you. We are committed to best practice in relation to the management of information we collect for you and this practice has developed a policy to protect patient privacy in compliance with privacy legislation.

This information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources such as other doctors, health providers or hospital.

I understand that I am not obliged to disclose my personal information requested of me but that my failure to do so may compromise the quality of the health care and treatment given to me.

I understand that I am entitled to access my own health care records except where access might be legitimately withheld. I understand that I will be given an explanation in these circumstances. I understand that I may withdraw my consent to the use and disclosure of my personal information (except where legal obligations must be met). For more information please refer to our website [www.drpeterfriedland.com.au](http://www.drpeterfriedland.com.au)

**Account information:**

I agree and acknowledge that I am responsible for payment of medical accounts on the day of service. I understand that I will be responsible for payment of debt collection fees applied to overdue accounts. I understand that a cancellation fee of \$25.00 may apply for less than 24 hours' notice to cancel an appointment or failure to attend an appointment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ **PLEASE TURN OVER PAGE AND COMPLETE**

Presenting Complaint



Adult & Paediatric Ear, Nose and Throat Surgeons

What is the reason for your visit? \_\_\_\_\_

Past Medical history Please check any problems you have had.

- Anxiety, COPD, Migraine Headaches, Palpitations, Deep Vein Thrombosis, Heart Attack, Asthma, Depression, Pulmonary embolism, Bleeding Disorder, Diabetes Mellitus, Seizures, Cancer, Emphysema, Skin Cancer, Chest Pain, Hearing Loss, Stroke, Chronic Lung Diseases, Hepatitis, Substance Abuse, Cirrhosis, High Blood Pressure, Syncope/fainting, Clotting disorder, kidney Disease, Thyroid Disease, Meningitis, Other (Please Specify)

Past Surgical History Please check any surgeries you have had and also approximate age of surgery.

- Ear surgery (left or right side? List procedure and approximate date), Adenoidectomy, Heart Surgery, Radiation Therapy, Sinus Surgery, Hernia Repair, Brain Surgery, Tonsillectomy, Hysterectomy, Cholecystectomy, Facial Surgery, Joint Replacement, Valve Replacement, Other Surgery (Please Specify)

Family History Please check any family conditions and approximate age of problem if know.

- Anaesthesia Problems, Bleeding Disorder, Cancer, Clotting Disorder, Hearing Loss, Heart Disease, Other (Please Specify)

Medications

List any medications you are currently taking below. Please indicate dose and frequency if known. Include any supplements, herbal and over the counter medication.

Table with 4 columns: Medication, Dose, Medication, Dose. Includes blank rows for patient input.

Social History

Relationship Status: \_\_\_\_\_

How Many Children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you drink alcohol? Yes No Type: \_\_\_\_\_ Amount Per Day: \_\_\_\_\_

Do you smoke? Yes No Amount Per Day: \_\_\_\_\_

Are you a former smoker? Yes No When Did You Quit? \_\_\_\_\_

Do you take recreational drugs? Yes No If yes, please provide details: \_\_\_\_\_

Systems Review Please check any current problems.

- Constitutional: Anorexia, significant reduced food intakes, chills, fatigue, fever, malaise (not feeling quite right), night sweats, sweats, weight loss
Eyes: Diplopia (double vision), lid erythema (redness), conjunctival redness (red eye), visual disturbance or loss
Ear, Nose & Throat: Nasal obstruction, nasal drainage, nosebleeds, snoring, throat pain, voice change, dysphagia (trouble swallowing)
Respiratory: Asthma, chronic bronchitis, cough, haemoptysis (coughing up blood), pneumonia, shortness of breath, stridor (noisy breathing in), wheezing (noisy breathing out)
Cardiovascular: Chest pain/pressure/discomfort, shortness of breath on exertion, palpitations, leg swelling, trouble breathing lying down, fainting
Gastrointestinal: Ulcers, reflux/heartburn, dysphagia (trouble swallowing), vomiting, diarrhoea
Genitourinary: Kidney disease, nocturia (urinating at night), urinary frequency
Skin/Breast: Skin lesion, breast lump
Blood/Lymph: Bleeding, easy bruising, blood clots, swollen lymph nodes
Musculoskeletal: Arthritis/joint inflammation or pain, bone pain
Neurological: Stroke, seizure, weakness, numbness, paraesthesia (burning or prickling sensation), speech problems
Psychological: Anxiety, depression
Endocrine: Cold/heat intolerance, excessive thirst
Allergy, immune: Hay fever, anaphylaxis, auto immune problem, immune suppression drugs