Patient Registration

Date

To help us provide you with the best possible care, please fill out our patient registration form.
This information will be kept on your file and treated as confidential (see Privacy Policy).

Estimated time to complete: 10 mins

STEP 1 OF 4

Consultation Details

Clinic Location

Specialist

Consultation Time

Consultation Date

Reason for visit

Patient Details

Title

First Name

Last Name

Date of Birth

Sex

Male Female

Street Address

Suburb

State

Postcode

Preferred Phone Contact

Work Phone

Mobile

Email

I agree to be contacted via phone and email

Yes No

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Patient Registration

STEP 1 OF 4 CONTINUED

Mailing Address

Address

Suburb

State

Postcode

Next of Kin

Full Name

Relationship to you

Phone

Mobile

STEP 2 OF 4

Please turn over to page 3 for step 2.

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Patient Registration

STEP 2 OF 4

Medical Information

Medicare Number

Card Reference No.

Expiry Date

Do you have Private Health Insurance?

☐ Yes ☐ No

Health Fund Name

Membership Number

Date Joined

Aged / Disability Pension

Do you have a Veterans' Affairs Card?

☐ Gold ☐ White

Card Number

Do you have Aged pension?

☐ Yes ☐ No

Pension number

Do you have Disability pension?

☐ Yes ☐ No

Pension number

General Practicioner

Full name

Address

Phone

Patient Registration

STEP 2 OF 4 CONTINUED

Finance

Person Financially Responsible

If other, please specify

Work Cover (if relevant)

Employer

Telephone

Address

Insurance Company

Claims Number

TAC (if relevent)

Date of Accident

Claims Number

STEP 3 OF 4

Please turn over to page 5 for step 3.

Patient Registration

STEP 3 OF 4

Medical history

Do you have or have you ever had any of the following?

Please respond to every question

Heart disease, heart attack or chest pain	Yes	No
Heart murmur, palpitations or irregular pulse	Yes	No
Rheumatic fever	Yes	No
Anaemia or blood disorders	Yes	No
Blood clots in the legs or pulmonary emboli	Yes	No
CVA/Stroke/TIA	Yes	No
Seizures/Fits, faints or blackouts	Yes	No
Bleeding problems or bruising	Yes	No
Hepatitis	Yes	No
Asthma	Yes	No
Diabetes	Yes	No
Reflux, hiatus hernia or ulcers	Yes	No
Thyroid disease	Yes	No
Kidney disease	Yes	No
High blood pressure	Yes	No
Cancer	Yes	No
Snoring, sleep apnoea or CPAP	Yes	No
Anxiety/Depression	Yes	No
Sexual dysfunction	Yes	No
Do you have family history of any of the above?	Yes	No

Do you have family history of any of these listed medical conditions?

Please specify

✓ Patient Registration

STEP 3 OF 4 CONTINUED

Surgical History

Please list ANY previous surgeries with approximate dates, and advise of any complications

Allergies

Please list ANY allergies you may have to medications, tapes, dressings, anaesthetics, lotions or foods.

STEP 4 OF 4

Please turn over to page 7 for step 4.

Patient Registration

STEP 4 OF 4

Current Medications:

Please list current medications including dosage (prescription & non-prescription)

Are you taking any of the following? ☐ Warfin ☐ Plavix/Clopidogrel ☐ Aspirin ☐ Prednisolone ☐ None of the above

Are you using any recreational drugs?

I smoke _____ cigarettes per day.

I stopped smoking _____ years ago.

How much alcohol do you drink? _____ per _____

How did you find out about LapSurgery Australia?

☐ I confirm that all my details provided in this form are accurate and that I have read and understood LapSurgery's Privacy Policy

☐ I consent to being contacted regarding research projects that LapSurgery Australia participate in

☐ I consent to receive correspondence via email when necessary

Please save completed form, and email to: admin@lapsurg.net.au

In the event any of the details on this form change, I acknowledge that I will advise LapSurgery Australia so that my records are up to date.

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