Level 8, 166 Gipps Street
East Melbourne VIC 3002
Phone (03) 9415 7622
Fax (03) 9415 9066
Provider No 26071FB
ABN 64 771 837

John Salmon
MBBS, FRACS
ORTHOPAEDIC SURGEON
Shoulder & Elbow Specialist

Park Clinic ORTHOPAEDICS
www.parkclinic.com.au

NEW PATIENT FORM

Welcome to the practice of Mr John Salmon.

Please complete this form to assist us in providing you with the best treatment. Please complete your Surname and Christian name as registered with Medicare.

Contact Details

Surname: ..... **First Name:** .....

Title: Dr / Mr / Mrs / Miss / Ms / Mast / Other: .....

Address: ..... Suburb: ..... Postcode: .....

Postal address if different to above: .....

Telephone: Home: ..... Work: ..... Mobile: .....

Email: .....

Date of birth: ...../...../..... Current Age: ..... Occupation: .....

Next of kin: ..... Phone: .....

Person responsible for fees: Self / Veterans Affairs / Parent: .....
(Name of Parent)

Health Fund Name: ..... Membership number: .....

Have you been with your health fund for longer than 1 Year: .....

Medicare number: __ __ __ __ __ __ __ __ __ __ REF No (in front of your name): ..... Valid to: ...../.....

Part of body needing treatment: ◯ Left ◯ Right: .....

Name of Referring Doctor: .....

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

.....

Do you have an Aged Pensioner card issued by Centrelink? YES / NO

Pension Number: ..... **Veterans Affairs Number:** .....

Practice Fees

	Cost	Aged Pensioner	Medicare Rebate
Initial	$ 200	$ 165	$ 72.75
Review	$ 110	$ 95	$ 36.55

There may be an additional charge for procedures undertaken (eg. injection, plaster,)

NOTICE ABOUT FEES:

All accounts must be settled on the day of consultation. **Any unpaid accounts for consultation or surgery will be sent to our debt collectors and you will be responsible for all additional 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:

I acknowledge that this practice does not see any work related injuries and consent that I will not be making a claim with workcover.

Patient Signature: .....

Date: ...../...../.....

Thank you.

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PATIENT HEALTH QUESTIONNAIRE

Full Name: .....

Please circle condition and tick where appropriate:	**YES**	**NO**
Have you ever had a heart attack?	◯	◯
Do you have an irregular heart beat / atrial fibrillation / murmour?	◯	◯
Do you have any implant device, pacemaker / stent?	◯	◯
Do you have a history of DVT / pulmonary embolism?	◯	◯
Do you have diabetes? Type 1 or Type 2	◯	◯
Do you have high blood pressure?	◯	◯
Do you have asthma or other shortness of breath?	◯	◯
Are you a smoker?	◯	◯
Have you or a family member had any problems with anaesthetics?	◯	◯

Please specify: .....

Do you have an allergies? YES / NO (If yes, please give details): .....

.....

Do you take any medications? YES / NO (If yes, please give details): .....

.....

Have you had any surgery in the past 10 years? YES / NO (If yes, what type): .....

.....

Patient Signature: .....

Date: ...../...../.....

Thank you.