PASO

PATIENT DETAILS

Title: _____ Surname: _____ Given name: _____

Date Of Birth: _____ Email: _____

Address: _____

Phone: _____ Mobile: _____ Occupation: _____

Nationality: _____ Country Of Birth: _____ Religion: _____

Referring Physician Name and Practice: _____

Gender (Please specify): _____ ☐ **I prefer not to say**

Marital Status (Please Tick): **Single** **Married** **Divorced** **Seperated** **Widowed** **De-Facto** **Other**

Are you of Aboriginal and/or Torres Strait Islander Descent? _____

I permit PASO Medical to contact me via SMS (Please Circle) YES NO
I permit PASO Medical to contact me via E-Mail (Please Circle) YES NO

NEXT OF KIN CONTACT

Name: _____ Relationship: _____ Phone: _____

MEDICARE INFORMATION

Medicare No. _____ Reference No. _____ Expiry Date: _____

Do you hold any of the below cards? (Please Tick) | If so please provide details

Healthcare Card
Pension card
Seniors Health Card
Department Of Veteran Affairs (DVA) Gold Card

Card Number: _____

Expiry Date: _____

PRIVATE HEALTH COVER

Do you have Private Health Cover? (Please Circle) YES NO

Name Of Fund: _____ Member No. _____ Reference No. _____

HAVE YOU HAD PRIVATE HEALTH INSURANCE FOR LESS THAN 12 MONTHS? _____
On your behalf, we are happy to forward your in-patient accounts direct to your private health fund

I CONSENT TO MY IN-PATIENT ACCOUNTS BEING FORWARDED DIRECTLY TO MY PRIVATE FUND AND UNDERSTAND THAT ALL IN-PATIENT ACCOUNTS ARE FULLY COVERED BY MEDICARE AND MY PRIVATE HEALTH FUND

Signature: _____ Date: _____

I understand that PASO Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to PASO Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems / registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand that I may request access to my personal information which may be granted in accordance with the Practice's Access to Personal Information Policy. I will be provided a written reason if access is denied. I understand that I may request an amendment to my personal information if it is incorrect. I will be provided with a written reason if a request for amendment is denied. I understand that my personal information will not be used for direct marketing or disclosed to overseas recipients. I understand I may withdraw my consent to PASO Medical to use and disclose my personal information (except when legal obligations must be met). I understand that I am not obliged to provide the Practice with my personal information, but withholding information may limit the Practice's ability to provide me with full service. I hereby authorise PASO Medical to access any relevant medical information required from other hospitals or medicare providers. I understand that I have a right to lodge a complaint about the handling of my personal information if I am dissatisfied which will be dealt with in accordance with the Practice's Complaint handling procedure.

Signature: _____ Date: _____

PLEASE NOTE: If you see the doctor on a day you have been admitted to Hospital for treatment, you are classed as an inpatient and we will automatically send your account through to your private health fund. If however on the day you see the doctor your treatment is not scheduled or you are currently not having any treatment as an inpatient, the cost of the consultation is payable by you, with a rebate available from Medicare. If you have any questions regarding the above, please speak to a receptionist.

PATIENT REGISTRATION FORM

PATIENT DETAILS

Title: _____ Surname: _____ Given name: _____

MEDICAL HISTORY

Past Medical History: Have you suffered from any of the following - currently or previously? (Please tick where applicable)

Heart Problems
Epilepsy
Back Pain
Liver Disease
HIV
High Cholesterol
Stroke
Other: _____

Hepatitis B
Hepatitis C
Kidney Disease
Cancer
High Blood Pressure
Asthma
Thyroid

Osteoporosis
Blood Clots
Bronchitis
Eye Problems
Fractures
Glaucoma
Diabetes T1 / T2: _____

Any recent blood tests or scans

_____

Height: _____ Weight: _____

Current Medications (Or Attach List - *Please include all tablets, inhalers, patches, gels or injections - as well as any other "Natural" remedies or supplements. Please include dosage and frequency as well):*

_____

_____

Smoker: YES NO If YES, how many per day: _____ Start Date: _____

Alcohol: YES NO If YES, quantity per week or per day: _____

SURGICAL HISTORY

List of Surgeries (Current / Past)	**Approx. Date / Year**
_____	_____
_____	_____
_____	_____
_____	_____

Any known allergies: _____

Any known reactions to anesthetic: _____

Relevant family history (Example: CA, Allergy to Anesthetic): _____

_____

Do you have an advance care directive? (Please Circle) YES NO

MENTAL HEALTH HISTORY

Have you in the past / Do you currently, suffer from Depression or Anxiety? _____

Any History of Self-Harm / Attempt to Suicide: _____

Current Medications or Interventions: _____

_____

The information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge

Signature: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY QUESTIONS