Oxford Dermatology & Day Surgery

RA-SF 10.2 Patient Details

Please Note: This information is required by the Health Department

PATIENT DETAILS -

Title: _______ **Surname:** _______________ **First Name:** _________________ **Middle Name:** __________________

Preferred Name: _________________ **Date of Birth** ___/___/____ **Country of Birth:** ______________________

Indigenous Status: _____________ **Marital Status:** _______________ **Employment Status:** _________________

Address: ____ **Suburb:** ____________________ **Postcode:** ________

Postal Address: (if different to home) ____

Phone (H): _________________________ **(M):** ___________________________ **(W):** _______________________

Email Address: ____

Next of Kin _______________________ **Relationship** ______________________ **Ph:** ______________________

Usual GP: ____ **Practice Location:** ___________________________

Medicare N° ___________________ **Ref N°** ____ **Expiry** _____ **Vet Affairs N°** _______________ **Colour:** Gold/White

Do you have private health insurance? Yes/No **Fund Name** ________________ **Member N°** ________________

Do you have hospital cover? Yes/No **Have you had hospital cover for more than 12 months?** Yes/No

Do you understand your Rights & Responsibilities as a patient? Yes/No (if no, please ask for a leaflet)

MEDICAL HISTORY- *Please complete all areas*

Current Medications (including: Warfarin, Aspirin, Clopidogrel/Plavix or any other blood thinners) ______________________

____

Please list any operations in the last 5 years or any illnesses currently being treated: _____________________

____

Please list any known allergies: ____

____

Do you, or have you ever had: *Please circle*

Severe Respiratory Disease   Heart Attack   Angina   High Blood Pressure   Bleeding Disorder   Diabetes

Artificial Heart Valves   Joint Replacement   Stroke   Unstable Cervical Spine   Cardiac Pacemaker/ Defibrillator

Are you currently pregnant? Yes/No

Do you have any of the following (*circle*):HIV, Hepatitis, TB, MRSA, CRE, VRE, other multi resistant organism? Yes/No

Have you worked in or been admitted to hospital in the last 12 months? No, Yes -WA, Yes- Interstate, Yes Overseas

Have you had any previous falls? Yes/No. If yes, please provide full details including date: ____________________

____

In the last 12 months have you had: Pressure injuries or sores? Yes/No *and/or* Deep Vein Thrombosis (DVT)? Yes/ No

Do you have an advanced care directive? Yes/No

I give permission for photographic medical images to be stored in my medical records to aid my clinical treatment. These images will not be used for commercial purposes. I understand any information supplied is confidential and my privacy is always maintained.

I declare that all information written on the above form is true to the best of my knowledge.

Signature ____ **Date** ______/_______/_______

ACCOUNT PAYER DETAILS - *Only fill in if payer details are different to information listed above.*

Account Payer: Parent / Guardian / Other:______________

Full name: Mr Mrs Ms Miss Dr **Surname**: ______________________________ **First Name:** ____________________________

Best contact number: __________________________ **DOB**:__________________

Address: ____

Medicare Number: ____ **Ref**:___ (next to name) **Expiry**: ____________

Office Use Only:

Processed by: ____

NP ☐ **Existing** ☐