DAVID SLATTERY
ORTHOPAEDIC SURGEON | FRACS MBBS(Hons.) LLB | FAOrthoA

# CONFIDENTIAL PATIENT INFORMATION

## PERSONAL DETAILS

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other _____ Date of Birth: ___/___/_____

Surname: _____ Given Name: _____

Address: _____

Suburb: _____ Postcode: _____

Email: _____

Occupation: _____

or School Year: _____ or University Year and Course: _____

## TELEPHONE NUMBERS

Home: _____ Work : _____ Mobile: _____

## NEXT OF KIN DETAILS (family member or friend / medical power of attorney)

Name: _____ Relationship to you: _____

Contact number: _____

Mother's Name: _____ Father's Name: _____

## CLAIM DETAILS

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Insurance: ☐ Yes ☐ No Fund Name: _____ Fund Number: _____

## CONCESSION CARDS

Aged or Disability Pension No: _____ Exp Date: _____

Dept. Veterans Affairs Card No: _____ ☐ White ☐ Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

WorkCover (If applicable) Claim No: _____ Insurer: _____

TAC Details (If applicable): Date of Accident: _____ Claim Number: _____

Usual GP Name: _____ GP Provider Number: _____

Practice details: _____

PLEASE TURN OVERLEAF

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# MEDICAL QUESTIONNAIRE

Regular Medications(Name, Dose, Frequency) : _____

_____

Have you had a DVT/ PE or Family History of PE/DVT? ☐ Yes ☐ No Have you ever had Heart Disease? ☐ Yes ☐ No

Do you suffer from Asthma? ☐ Yes ☐ No If Yes, how is your Asthma managed? _____

Have you had adverse reactions to anaesthetics or family history of adverse anaesthetic reactions? ☐ Yes ☐ No

If Female: – Is there any chance you are pregnant? ☐ Yes ☐ No
(We may require X-rays or surgery both of which can affect pregnancy)

Are you allergic to any medicines, tapes or latex: ☐ Yes ☐ No If yes, please specify: _____

_____

## AUTHORISATION AND CONSENT TO PHOTOGRAPHY/VIDEO

I, _____ consent that photographs be taken of me by Dr David Slattery.

Dr David Slattery at all times respects patients right to privacy and informed consent for procedures within the practice including photographic records. I understand that these photographs form an essential part of my medical record as well as my preoperative and postoperative assessment. I understand and consent to my photographs being used by Dr David Slattery for medical research, teaching and or patient education purposes. I understand that I will not be identified by name in any such use of these photographs, however in some circumstances the photographs may portray features that shall make my identity recognisable.

I give permission for Dr David Slattery or his staff to contact me by telephone and if necessary leave a message.

I have read all of the above and all my questions have been answered.

Signature _____ Date: ___/___/_____

## HEALTH RECORDS ACT 2001 COLLECTION STATEMENT

Dr David Slattery is collecting your health information for providing you with health services. Please read and sign to give approval for this information to be collected and stored. Your medical information will be used exclusively for providing health care in the following way:

- To gain a history, diagnose disease and provide treatment where necessary;
- Administrative purposes in running this Practice, which may also include confirmation of your appointment.
- Writing reports to your Doctor and other Doctors involved in the provision of healthcare, and the storing of reports provided to this Practice by other Medical Specialists; and
- Billing and collection purposes, including but not limited to compliance with Private Health Fund, Medicare and Health Insurance Commission requirements. You may gain access to your health information by writing to us. If you do not consent to providing us with your health information we may be unable to provide you with health services.

I consent to Dr David Slattery collecting my health information Signature: _____ Date: ___/___/_____

## REFERRAL SOURCE: HOW DID YOU HEAR ABOUT DR DAVID SLATTERY?

Referred by Doctor ☐ GP or ☐ Specialist

☐ Our Website www.davidslattery.com ☐ or Royal Australian College of Surgeons (RACS) website

☐ Google ☐ Yellow Pages ☐ Social Media ☐ Personal recommendation: _____

☐ Other: _____

## ALL CONSULTATIONS ARE PAYABLE AT THE TIME OF SERVICE

We accept payment via direct deposit, VISA/AMEX/Mastercard, Cheque or Cash

PLEASE TURN OVERLEAF

Practice (03) 9819 6934 | Fax (03) 9815 3944 | 24hr Referral line 0475 582 244 | Email admin@davidslattery.com

CONSULTING ROOMS

GLENFERRIE PRIVATE HOSPITAL
29 Hilda Cres, Hawthorn, 3122

ROYAL CHILDREN`S HOSPITAL
50 flemington rd, Parkville 3052

THE AVENUE HOSPITAL
40 the avenue, Windsor vic 3181

davidslattery.com