Dr Mark Shillington
B.Phty, M.B.B.S, M.Eng (Biomedical), FRACS (Orth)
ORTHOPAEDIC SURGEON

p 07 3819 0044
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a 2 Gray Street Ipswich Qld 4305
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Registration Form

PATIENT DETAILS

Title: _____ First Name: _____Surname: _____

Date of Birth: _____/_____/_____

Address: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

MEDICARE DETAILS

Medicare No: _____ Ref: _____ Exp: _____

PATIENT/CARER DETAILS (IF PATIENT IS A MINOR)

Full Name: _____ DOB: _____

Medicare No: _____ Ref: _____

NEXT OF KIN/EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship:_____

PRIVATE HEALTH FUND DETAILS (HOSPITAL COVER ONLY)

Private Health Fund: _____ Membership No: _____

DEPT OF VETERANS AFFAIRS DETAILS

DVA Card: Gold / White (please circle)

Card Number: _____

White (Related Injury): _____

WORKERS COMPENSATION DETAILS

Workers Compensation Claim No: _____

Employers Name: _____ Injury Date: _____

SMS APPOINTMENT REMINDERS

Do you wish to receive appointment reminders via SMS? Yes / No (Please circle)

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Privacy Information:

To enable the ongoing provision of care within this practice, and in keeping with the Privacy Act and Australian Privacy Principles (APPs), we wish to provide you with information on how your personal and health information may be used or disclosed. Westside Orthopaedics and Sports Medicine Clinic collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. Your personal and health information will only be used for the purposes for which it is collected, or as otherwise permitted by law.

Consent:

I have read the information above and understand the reasons why my information must be collected. I consent to the use of my personal and health information by Westside Orthopaedics and Sports Medicine Clinic and other health providers involved in my care. I consent to the disclosure of my personal and health information by Westside Orthopaedics and Sports Medicine Clinic to other health providers directly or indirectly involved in my personal health care or medical treatment.

I give my consent to Westside Orthopaedics and Sports Medicine Clinic to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care. I authorize those medical practitioners or bodies to release such information as requested.

Signature _____ Date _____

- High blood pressure
- TIA
- Chronic Lung Disease/COPD
- Atrial Fibrilation
- Cardiac History
- Diabetes
- Asthma
- Stroke
- Blood Clots / PE / DVT

MEDICAL INFORMATION

BLEEDING DISORDERS

Do you have a history of any bleeding disorders? Yes / No

Is there a family history of any bleeding disorders? Yes / No

MEDICATIONS

Do you currently take any blood thinning medication? Yes / No

CURRENT MEDICATIONS:	**ALLERGIES:**

SMOKING AND ALCOHOL HISTORY

Smoking (please circle) Current / Former / Non Smoker

Do you drink alcohol (please circle)? Yes / No Drinks per week: _____