

NEW PATIENT REGISTRATION FORM

SURNAME _____ MR/MRS/MS/MISS/DR

FIRST NAME _____

ADDRESS _____

POSTCODE _____ PHONE _____ MOBILE _____

EMAIL _____

DATE OF BIRTH / /

NEXT OF KIN NAME/PHONE _____ RELATIONSHIP _____

NAME/ADDRESS OF LOCAL DOCTOR _____

MEDICARE NO _____ REF NO (next to your name) _____

EXPIRY DATE _____

PRIVATE HEALTH FUND/LEVEL OF COVER _____ / _____

HEALTH FUND MEMBERSHIP NO. _____

VETERANS AFFAIRS LEVEL/NO. _____ / _____

PENSION CARD NO/EXPIRY DATE _____ / _____

TAC/WORKCOVER NO _____

TAC/WORKCOVER INSURER _____

TAC/WORKCOVER CASE MANAGER NAME _____

TAC/WORKCOVER CASE MANAGER PHONE _____

HOW DID YOU HEAR ABOUT DR YUEN? _____

MEDICAL INFORMATION

(Circle if applicable)

LEFT OR RIGHT **HANDED?**

MEDICATIONS

ASPIRIN (Solprin, Disprin, Aspro, Aspalgin) CLOPIDOGRIL (Plavix, Cloplavix)
APIXABAN (Eliquis) DABIGATRAN (Pradaxa) RIVAROXABAN (Xarelto)
WARFARIN CLEXANE/HEPARIN EPILIM JANUMET
OTHER BLOOD THINNERS

HERBAL SUPPLEMENTS

ST JOHN'S WORT GINSENG GARLIC GINGER
GINKO BILOBA TUMERIC

MEDICAL CONDITIONS

HIGH BLOOD PRESSURE DIABETES HEART ATTACK HEART
SURGERY/STENT STROKE CANCER
ASTHMA/COAD/EPHYSEMA SLEEP APNOEA

(List if applicable)

OTHER CURRENT MEDICATIONS

PREVIOUS SURGERY

DRUG ALLERGIES/REACTIONS

PROBLEMS WITH ANAESTHETICS

SIGNED _____ **DATE** _____

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