Dr Greggory Burrow
MBBS FRACS Orthopaedics

New patient details:

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Master ☐ Other: ______________________________

First Names: ______________________________ Surname: ______________________________

Preferred Name: (if any) _________________________ Date of Birth: __ __ / __ __ / __ __ __ __

Phone: (H) ____________________ (W) ___________________ (M) ______________________

Email: ____

Address:____

Suburb: ____State: __ __ __ Post Code: __ __ __ __

Billing Address: ____

Next of Kin: _____________________________ Contact Number: _________________________

Relationship: ____

Family Doctor: ____

Address: ____

Referring Doctor:____

Address: ____

Physiotherapist:____

Address: ____

How did you hear about us? Past Patient: ☐ GP: ☐ Physio: ☐ Surgifind: ☐ Web: ☐ Friend: ☐

Private Health Fund: __________________________No: _______________________ Ref No:___

Do you have? Pension Card: ☐ Health Care Card: ☐ DVA Gold Card: ☐ DVA White Card: ☐

What is the Card No: ____ Exp: __ __ / __ __ __ __

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: ___ Exp: ___ ___ / ___ ___ ___ ___

If the patient is under 16 years of age, please provide your Medicare details below:

Parents name: _________________________________ Ref: ____ DOB: __ __ / ___ __ / __ __ __ __

Workers compensation:

Claim no: ______________________________________ Date of Injury: __ __ / __ __ / __ __ __ __

Insurance company: _____________________________ Case Manager: ______________________

Insurance Address: ____

Phone: __________________ Fax: ________________ Email: ______________________________

Employer: ____ Phone: ________________________

Employer Address:____

Privacy

Permission to Collect and Store Information:

I have read the above and agree to the collection and storage of information. I authorise Dr Greggory Burrow to release medical information to the Referring Doctor/GP/Physio/Insurance Company/Solicitor or to the persons nominated by me.

Signed:____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

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Patient Medical History:

Name: ___________________________________ Age: _____________ Hand Dominance: Right: ☐ Left: ☐

Weight: ________________________kgs/lbs Height: ________________________cm/in

Do you Smoke? Yes:☐ No: ☐/ Have you smoked? Yes:☐No: ☐ (Amount/per day?)________________________

Do you Drink? Yes:☐ No:☐ (Amount/per day?) ____

Do you have allergies?: ____

What previous surgeries have you had?: ____

____

Have you ever had complications after surgery?: ____

____

Have you had any previous anaesthetic problems?: ____

____

Has a family member had any previous anaesthetic problems?: ____

____

Please list any current medication: ____

____

Have you had any infectons?: ____

____

Blood Thinners?	Yes ☐	No ☐	**Plavix/Asprin?**	Yes ☐	No ☐
High Blood Pressure?	Yes ☐	No ☐	**Cancer?**	Yes ☐	No ☐
Diabetes?	Yes ☐	No ☐	**Insulin?**	Yes ☐	No ☐
Sleep Apnoea?	Yes ☐	No ☐	**Sleep Machine?**	Yes ☐	No ☐
Asthma?	Yes ☐	No ☐	**Hepatitis?**	Yes ☐	No ☐
Heart Attack?	Yes ☐	No ☐	**Liver problems?**	Yes ☐	No ☐
Valve Replacement?	Yes ☐	No ☐	**Stomach Ulcers?**	Yes ☐	No ☐
AF/Rhythm Problems?	Yes ☐	No ☐	**Indigestion?**	Yes ☐	No ☐
Stroke?	Yes ☐	No ☐	**Prostate?**	Yes ☐	No ☐
DVT/Blood Clots?	Yes ☐	No ☐	**Epilepsy?**	Yes ☐	No ☐
Depression?	Yes ☐	No ☐	**Thyroid Conditions?**	Yes ☐	No ☐

Do you have any implants? Plate/Wires/Screws? ☐ A Joint Replacement? ☐ A Pace Maker? ☐

Breast? ☐ Other? ☐ Please list: ____