Kaliper Orthopaedics

Dr Kalman Piper
MBBS FRACS (Orth)
Orthopaedic Surgeon
Arthroscopic & Open Shoulder Surgery

New Patient Registration Form

Patient Details

Title::_ _ _ First Name: _ _ _ _ _ _ _ _ _ _ Middle: _ _ _ _ _ _ _ _ _ Surname: _ _ _ _ _ _ _ _ _ _ _ _ _

Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Home Phone: (_ _) _ _ _ _ _ _ _

Suburb: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Work Phone: (_ _) _ _ _ _ _ _ _

State: _ _ _ _ Post Code: _ _ _ _ Mobile Phone: _ _ _ _ _ _ _ _ _ _

Date of Birth: _ _ /_ _ / _ _ _ _ Email: _

Are you happy to use SMS to confirm appointments with Dr Piper? Yes ☐ No ☐

Occupation: _ _ _ _ _ _ _ _ _ _ _ _ _ Parents Name (if < 18y): _ _ _ _ _ _ _ _ _ _

Name of Next of Kin: _ _ _ _ _ _ _ _ _ _ _ _ _ Telephone: _ _ _ _ _ _ _ _ _ _

Health Insurance

Medicare Number: _ _ _ _ / _ _ _ _ _ / _ Ref :(No next to name): __ Expiry: _ _ / _ _ _ _

Private Fund: _ _ _ _ _ _ _ _ _ _ _ _ _ Membership Number: _ _ _ _ _ _ _ _ _ _

DVA Number: _ _ _ _ _ _ _ _ _ _

General Practitioner & Physiotherapist

Is the referring GP your usual GP? Yes ☐ No ☐ If no, please provide FULL NAME AND ADDRESS OF USUAL GP (if this is provided a copy of correspondence can be sent).

Usual GP : _ _ _ _ _ _ _ _ Address: _ _ _ _ _ _ _ _ _ _ _ _ _: _ _ _ _ _ _ _ _ Ph: (_ _) _ _ _ _ _ _ _ _

Physiotherapist _ _ _ _ _ _ _ _Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Ph:: (_ _) _ _ _ _ _ _ _ _

Are you making a claim for Compensation? No ☐ or please select:

Workers Compensation ☐ CTP ☐ Personal Injury ☐ Public Liability ☐

Employer Name: _ _ _ _ _ _ _ _ _ _Employer Phone: (_ _) _ _ _ _ _ _ _ _

Insurance Company Name: _ _ _ _ _ _ _ _ _ _ _ _ _Ins Phone: _ _ _ _ _ _ _ _ _ _ _ _

Date of Injury: _ _/ _ _ / _ _ _ _ Case Manager: _ _ _ _ _ _ _ _ _ _ Claim Number: _ _ _ _ _ _ _ _ _ _ _

Declaration and consent for information (Privacy Act):

I give permission for my information to be kept for the purposes of administrative and billing purposes, and for my health information to be sent to health practitioners, hospitals and insurance companies where appropriate.

I undertake to pay all fees owing to my Surgeon, including outstanding accounts that have not been paid in full by my insurer, in the event that liability is denied. I also understand that any outstanding monies requiring debt recovery will incur debt recovery fees and I will also be responsible for any legal costs incurred.

Signature of patient or parent / guardian _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **Date:** _ _/_ _/_ _ _ _

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Patient Medical History

Name _ Hand Dominance: Left ☐ Right ☐ Ambidextrous ☐

Sports Played: _ Competition Yes ☐ No ☐

Previous Surgery: _

Current Medications: _

Do you take: Warfarin ☐, Aspirin ☐, Herbal Medications ☐, or Pain Medications ☐.

Allergy to Medications: _

Shoulder Symptoms Start Date: _ _ _ _ _ _

- Side: Left ☐ Right ☐ Both ☐
- Injury: No ☐ Yes – Date:_ _ _ _ _
- Pain from 0 (no pain) to 10 (Max) _ _ _
- Stiffness Yes ☐ No ☐
- Weakness Yes ☐ No ☐
- Dislocations Yes ☐ No ☐
  - How Many? _ _ _
- Previous Treatment:
  - Physio Yes ☐ No ☐
  - Injections Yes ☐ No ☐
    - Number _ _ _
  - Surgery Yes ☐ No ☐
    - When __ _ _ _ _ _ _ _

Arthritis:

- Osteoarthritis Yes ☐ No ☐
- Rheumatoid Arthritis Yes ☐ No ☐

Past Blood Transfusion: Yes ☐ No ☐

Cancer:

- Breast Yes ☐ No ☐
- Mastectomy Yes ☐ No ☐
- Shoulder Region Yes ☐ No ☐
- Other: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Cardiac Problems:

- Heart Attack Yes ☐ No ☐
- High Blood Pressure Yes ☐ No ☐
- Low Blood Pressure Yes ☐ No ☐
- Other: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Diabetes: Yes ☐ No ☐

- Diet controlled ☐
- Tablet controlled ☐
- Insulin controlled ☐

Epilepsy: Yes ☐ No ☐

- Epilepsy Tablets Yes ☐ No ☐

Gastric Problems:

- Indigestion / Reflux Yes ☐ No ☐
- Stomach Ulcer Yes ☐ No ☐

HIV / AIDS: Yes ☐ No ☐

Kidney Conditions: Yes ☐ No ☐

Liver Disease:

- Alcohol intake / day _ _ _ _ _ _ _ _ _
- Hepatitis B or C Yes ☐ No ☐

Lung Conditions:

- Asthma Yes ☐ No ☐
- Smoker – Never ☐ Quit ☐ Yes ☐
- Cigarettes / day _ _ _
- Emphysema Yes ☐ No ☐
- Sleep Apnoea Yes ☐ No ☐
- Pulmonary Embolus Yes ☐ No ☐

Stroke(s): Yes ☐ No ☐

Thyroid Conditions:

- Hyper-active Yes ☐ No ☐
- Hypo-active Yes ☐ No ☐

Venous Conditions:

- DVT (Thrombosis) Yes ☐ No ☐
- Varicose Veins Yes ☐ No ☐

Other conditions: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Breast Augmentation: Yes ☐ No ☐

I certify that all the information given is correct and true to the best of my ability.

Signature of patient or parent / guardian _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **Date:** _ _/_ _/_ _ _ _