PATIENT INFORMATION SHEET

Dr Marcus Chia
SHOULDER & ELBOW SURGEON
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Mr/Mrs/Miss/Ms/Dr (circle)

Given Names:_____ Surname:_____

Address:_____DOB:_____/_____/_____

_____Postcode:_____

Phone H:_____ W:_____M:_____

Email: _____ Occupation: _____

Emergency contact:_____Relationship:_____Phone:_____

Medicare No:_____ Position on card :_____Valid to :_____

Private fund:_____ Membership No:_____

Health Care/Pension/DVA (Circle) Card Number : _____ Expiry: _____

Account to (if child)_____Parent DOB:_____

Parent Medicare No:_____ Position on card :_____Valid to:_____

General Practitioner:_____ Phone:_____

Address:_____ Postcode:_____

Worker's compensation: Type of injury:_____ Date of injury:_____

Insurance company:_____ Claim No:_____

Case Manager:_____ Phone:_____

Employer:_____ Phone: _____

Address:_____ Postcode:_____

Physiotherapist:_____ Phone:_____

Physio Address:_____

Postcode:_____

How did you hear about Dr Chia? GP / Specialist / Emergency / Physio / Word of mouth / Internet

Other (please specify):_____

Symptoms

Shoulder ☐ Elbow ☐ N/A ☐

Right ☐ Left ☐ Both ☐

Hand dominance? Right ☐ Left ☐ Ambidextrous ☐

When did the symptoms start? _____ (days, months, years)

Were they from an injury? Yes ☐ No ☐ Unsure ☐

If so, what type of injury? _____

Do you have any stiffness? Yes ☐ No ☐

Do you have any weakness? Yes ☐ No ☐

Have you ever dislocated your shoulder/elbow? Yes ☐ No ☐ If yes, how many times? _____

What treatment have you had:

Physiotherapy Yes ☐ No ☐

Injections Yes ☐ No ☐

Surgery Yes ☐ No ☐

Do you take pain medications? Yes ☐ No ☐ If yes, what? _____

Do you take any herbal medications? Yes ☐ No ☐ If yes, what? _____

Are you taking any blood thinners? Yes ☐ No ☐ If yes, what? _____

Other treatment Yes ☐ No ☐ If yes, what? _____

Are you retired? Yes ☐ Semi-retired ☐ No ☐ What is (or was) your occupation? _____

Sports you play: _____

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.
- Research and teaching purposes (all information, medical imaging and clinical photography used will be de-identified)
- Please be advised that consultations may be recorded and transcribed by an AI system for documentation purposes.

Signed:…… Date:……..