Ballarat Cardiology - Patient Registration Form (2018)

Title: Mr / Mrs / Ms / Miss / Mst / Dr / Other_____(please circle) **Date of Birth: _____**

Given Names:_____ Surname: _____

Residential Address:_____

Postal Address:_____

Email Address: (if used regularly) _____

Mobile: _____ Home Phone: _____ ___ Business: _____

Emergency Contact Person:_____ Relationship: _____

Phone:_____ Address:_____

Referring Dr: _____

Name of your usual Dr (GP)**: _____**

Medicare Number: _____Reference Number: _____

Private Health Insurance

***Please Note,** if you have Private Health Insurance it is a requirement of our Practice that you provide the following information prior to attending your appointment with our doctors. If you aren't sure what level of cover you hold with your Private Health Fund please contact them to obtain.

Do you have Private Health Insurance? Yes: _____ No:_____

Fund:_____

Member Number:_____ Level of Cover:

Do you have an excess to pay? Yes: _____ No: _____ __

Have you served your waiting periods? Yes:_____ No:_____

If No, when does your waiting period end?: Date: _____/_____/

Are you covered for Cardiac Care in a PRIVATE Hospital? Yes: _____ No: ____

If No, Are you Covered for Cardiac Care in a PUBLIC Hospital? Yes: _____ No: _____

Concession Card Holders

If you are a pensioner of HCC holder you may be entitled to a discount on your fees, depending on the specialist fee policy. To be eligible for this discount we must sight your pension or HCC card.

Pension card number: (Blue Pension Card)_____**Exp Date: ___/__**

HCC number: (Yellow & Red Card) __ _____**Exp Date:___ /__**

Veterans Affairs Card Number: _____

TAC: _____

If your consultation is related to a work cover claim please provide your claim details:

W/C Insurer: _____ Claim Number: _____ (It is important that you have approval to claim for the consultation, if not you are liable for the cost of the consultation and you can claim back from your work cover insurer once your claim has been approved.)

Consent to Release Medical Documents (2018)

Have you had any recent admission to Hospital relating to your heart? Yes:_____ No: _____

If Yes, Which Hospital: _____

Date of Admission:_____

Have you seen a Cardiologist in the past? Yes:_____ **No:**_____

If Yes, Name of Cardiologist: _____

Clinic Name: _____

Have you had any recent Cardiac related tests?

ECHOCARDIOGRAM: (ultrasound of your heart) Yes: __ Location**:** _____

CHEST X-RAY: Yes:____ Location**:** _____

24 HOUR HOLTER MONITOR: Yes: Location: _____

ECG: Yes: Location**:**

24 HOUR BLOOD PRESSURE MONITOR: Yes: Location**:** _____

CT SCAN: (ie: CT Chest / CT Coronary Angiogram) Yes: Location: _____

CARDIAC MRI: (MRI of your heart) Yes: Location: _____

STRESS ECHOCARDIOGRAM: (MIBI stress test) Yes: Location: _____

OTHER:

Name of Test/s and Location:

Have you had any recent pathology blood tests? Yes: ____ **No:**____

DOROVITCH:_____ **CLINICAL LABS:**

MELB PATH: _____ **OTHER:** _____

Have you had any recent Cardiac related Procedures?

CORONARY ANGIOGRAM: Hospital: _____ Date**:** _____

DIRECT CURRENT REVERSION (DCR)**:** Hospital: _____ Date**:** _____

TRANSESOPHAGEAL ECHOCARDIOGRAM : Hospital: _____ Date:____

PACEMAKER or DEFIBRILATOR INSERTION: Hospital: _____ Date:_____

BRAND OF PACEMAKER/DEFIBRILATOR:

I _____*consent to the release / access by the Ballarat Cardiology staff of my medical record to / of any health service provider that requires the information for the purpose of treatment or audit of my current, past or any future conditions.*

_____

_____

Signed

Dated

Medications List (2018)

Full Name: _____ **Date of Birth:** ___/___/____

Do you take the following Medication?

Aspirin: **Cartia:**

Plavix: **Clopidogrel:**

Warfarin: **Other blood thinning agent:**

Do you take any other Medication Regularly? If yes, Please list below:

Medication: **Reason for taking** e.g. Blood Pressure

Are you Allergic to anything?

If yes, Please list below:

Allergy: **Type of Reaction:**

In order for our Cardiologists to provide correct care during your initial and future Consultations we require all of the above Information to be mailed, faxed, emailed or dropped into our clinic no later than 1 week prior to your Appointment.

In Person: Ballarat Cardiology, Ground Floor St John of God Hospital, 101 Drummond Street North Ballarat.

Mail: PO Box 534W, Ballarat West, VIC 3350

Email: reception@ballaratcardiology.net.au

Phone: 03 53292111

Fax: 03 53261217

We look forward to seeing you soon.

Reception Staff

Ballarat Cardiology