Dr Andrew Kam's Clinic

Clinical Information Form - Confidential (PLEASE COMPLETE ALL PAGES)

Surname: ………………………………… First: ……….……………… Title: Dr Mr Mrs Ms
Address: ………………………………….………………………...……………(Home): ………………..…..
……….…………………………………………………………………….(Work): ……………………..
Email address: ………………………………………………………… (Mob) ………………………
Date of Birth:……………….. Age: …..….…yrs Height: ……….... Weight: ………..kg
Medicare No: ……………………………… Exp: ...……... Ref No: ……………….
Vet. Affairs No: …………......…….
Health Fund: ……………………………..... Membership No: ………………………….……………
Occupation: ………………… Pension Type: ……………………. Pension No: …………...………

Worker's Comp/Third Party Claim No: ……………………………. Date of injury: ………………
Insurance Co: ………………..…………………………………………….
Postal Address: ……………………………………………………………………………………...
……………………………………………………………………………………… Postcode…………

Referring Doctor: …………………………………………. ………………
Address: ……………………………………………………..…………………..
………………………………………………………….Postcode…………Tel No: ……………

GP: ……………………………………………………………..……………Tel No: ………..……
Address: …………………………………………………………………..……Postcode…………

Reason for referral: ………………………………………………………………………………

Do you smoke? Yes/No How much?…………..
Do you drink alcohol? Yes/No How much?………..….

Are you taking Aspirin, Cardiprin, Dispirin? Yes/No

Are you taking Blood Thinners (Warfarin, Persantin, Dipyridamole Ticlopidine, Plavix,) Yes/No

Do you suffer from (**PLEASE TICK THE BOXES**)

Heart Disease

- ☐ High Blood Pressure
- ☐ Angina
- ☐ Abnormal Heart Beat
- ☐ High Cholesterol
- ☐ Heart Attacks
- ☐ Heart Failure
- Others

Lung Disease

- ☐ Asthma
- ☐ Chest Infections
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Blood Clots in the Lung
- ☐
- Others

Gastric Problems	☐ Peptic Ulcer ☐ Gall Bladder	☐ Hepatitis ☐ Liver Failure	Others
Kidney Disease	☐ Bladder Infections ☐ Kidney Stones	☐ Kidney Infections ☐ Kidney Failure	Others
Neuro Problems	☐ Strokes ☐ Epilepsy	☐ Dizziness ☐ Foot drop	Others
Hormonal Problems	☐ Diabetes ☐ Osteoporosis	☐ Thyroid Disease ☐	Others
Malignancy	☐ Brain Tumour ☐ Breast Cancer ☐ Bowel Cancer	☐ Lung Cancer ☐ Prostate Cancer ☐ Skin cancer	Others

Previous Operations	**Year**	**Previous Operations**	**Year**

Current Medications	**Dose**	**Times per day**

Drug Allergy	**Type of Reactions**

Thank you for completing this information sheet

DR ANDREW KAM – CONSULTATION FEES

We wish to advise that Dr Andrew Kam's Standard Fees for consultation are above the Government determined Schedule Fees.

I, **……………………………………………,** hereby acknowledge that I am seeing Dr Andrew Kam as a **PRIVATE PATIENT** (not Workers Compensation, Third Party or any other type of compensable injury). I understand that he **WILL NOT** be preparing medico-legal reports for me or providing reports or correspondence to any insurance company or solicitor. **I understand that if any unpaid account is not settled within 30 days, a late payment fee of 25% will be incurred and the matter will be referred to our collection agency.**

PRIVACY IN OUR MEDICAL PRACTICE

The Privacy Act 1988 and its recent amendments formalised the already existing and knowledged privacy obligations of our practice. Dr Kam and staff collect information from patients primarily to provide proper care and treatment. We have a legal and ethical duty to protect patient information. Patient information may have to be disclosed to other doctors, nurses, therapist, and medical technicians so that healthcare is not compromised.

SIGNED: ……………………………………………..DATED: ……/……/..……

WITNESS: …………………………………………….

WORKER'S COMPENSATION / THIRD PARTY

I, **……………………………………………,** hereby acknowledge that I am seeing Dr Andrew Kam for his assessment, advice and if necessary, surgical management of my condition which is covered under **WORKER'S COMPENSATION,THIRD PARTY OR OTHER COMPENSABLE INJURY.** I understand that I am responsible for payment of all consultation fees incurred at the time of consultation. I understand that payment of all consultation fees must be made prior to seeing Dr Kam.

I hereby authorize that the information concerning my condition and treatment will be forwarded to my Worker's Compensation Insurer/Third Party Insurer. **I understand that Dr Kam does not provide medicolegal reports for solicitors.**

I undertake to be **FULLY RESPONSIBLE** for all outstanding fees for consultations and treatment. **I understand that if any unpaid account is not settled within 30 days, a late payment fee of 25% will be incurred and the matter will be referred to our collection agency.**

SIGNED: ……………………………………………..DATED: ……/……/..……

WITNESS: …………………………………………….