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Dr Sunny Randhawa
MBChB(RCSI) FRACS FA(Orth)A MPH(UNSW)
Hip, Knee & Trauma Surgeon

NEW PATIENT INFORMATION

Date: ______________________________

Title: Mr / Mrs / Ms / Miss / Other: __________________ Date of Birth: ______________________________

First Name: ______________________________ Middle Name: ______________________________

Surname: ______________________________ Known as: ______________________________

Street Address: ____

Suburb: ______________________________ State: ______________ Postcode: ________________

Home Phone: ______________________________ Mobile: ______________________________

Email: ____

Work Phone: ______________________________ Occupation: ______________________________

If under 18 years old:

Parent / Guardian: ______________________________ Date of Birth: ____________________

Phone: ______________________________ Email: ______________________________

Address (if different): ____

Next of Kin: ______________________ Relationship: ______________ Phone: ________________

Referring Dr: ______________________________ Address: ______________________________

GP (If Different): ______________________________ Address: ______________________________

Physiotherapist: ______________________________ Address: ______________________________

Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ Ref No: ☐

Health Fund: ______________________________ Member No: ______________________________

DVA Number: ____________________ Card: ☐Gold ☐ Silver ☐White: ______________________________

Pensioner: Type: Aged / Disability / Other Card Number: ________________________ Exp: ________/______

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Are you making a Claim: ☐Worker's Compensation ☐ Third Party Claim ☐ Other: ____________________

Insurance Company: ____________________________ Address: ____________________________________

Claim No: _______________________ Date of Injury: ____________ Case Manager: __________________

Email: _______________________________________ Phone: _____________________________________

Employer: _____________________________ Address: ____

DECLARATION

I hereby certify that the medical information I have provided above is true and accurate to the best of my ability.

Privacy Act: I __________________________________, agree to allow Dr Sunny Randhawa access to all relevant information regarding my medical condition. I agree that Dr Randhawa will be required to forward medical information about my presenting medical condition and/or medical history to other health care providers or insurers as required. I understand that to provide the highest medical care, my clinical records may be accessed or reviewed by the staff in this practice.

I undertake to pay all fees as a private patient owing to Dr Randhawa.

For insurance claims; I undertake to pay any fees owing to Dr Randhawa should I wish to proceed with treatment without prior written approval from my insurance company.

I also understand that any outstanding monies requiring debt recovery will incur debt recovery fees and I will be responsible for any legal costs if required.

Name: _________________________ Signature: ___________________________________ Date: _______

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MEDICAL HISTORY

Name: ________________________________ Age: ________ Height: ___________ Weight: ___________

Treatment Area / Presenting Problem: Please Tick: ☐ Left ☐ Right ☐ Both

☐ Hip ☐ Knee

Presenting Problem Description: ____

____

____

Allergies to Medications, metals or other:

____

____

____

Current Medications, including natural/herbal medicines:

____

____

____

Other specialists involved in your care:

____

____

____

Previous Surgeries, including dates if possible:

____

____

____

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Do you have, or have you ever had any of the following conditions?

Please answer every question with a tick for Yes or No, and circle where appropriate.

	If Yes, please circle	**No**
Blood Thinners	Aspirin Warfarin Anti-Inflammatories Herbal Medicines	
Cardiac Conditions	Cardiac Surgery Pacemaker/Stent Heart Attack/s Heart Murmur High Blood Pressure Stroke	
Diabetes Type: ___________	Diet Tablets Insulin	
Gastric Conditions	Stomach Ulcer Indigestion / Reflux	
Lung Conditions	Asthma Emphysema Sleep Apnoea If Yes to Sleep Apnoea – CPAP: ______________________	
Tobacco	Never Irregular Several per week Daily – How many: _____ Ex-Smoker – How long did you smoke: _______	
Liver Conditions	Hepatitis – What type: _________	
Alcohol	Never Rarely Several per week Daily – How many: ________	
Venous Conditions	Thrombosis (DVT) Varicose Veins	

If you answered yes above, please provide further details on any condition requiring further explanation.

____

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