Melbourne Spine Studio

p: 03 8849 0198
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PO Box 338, Toorak VIC 3142
info@melbournespinestudio.com.au
melbournespinestudio.com.au

# NEW PATIENT REGISTRATION AND CONSENT

Welcome to Melbourne Spine Studio.
We aim to provide you with the best possible evidence-based treatment and personalised care. Please complete all sections and read the Personal & Health Information Consent section at the end of this form. Please contact reception if you have any questions or require assistance completing this form.

Title: □ Prof □ Dr □ Mr □ Mrs □ Ms □ Miss □ Others: _____
Given Names: _____ Surname: _____
Preferred Name: _____ Date of Birth: _____

Australia is a gender-inclusive and multicultural society. We tailor appropriate care and encourage understanding and appreciation between people from different genders, nationalities, and cultural backgrounds. Knowing your background can help us provide healthcare that meets your individual needs.

Sex: □ Male / □ Female / □ Non-Binary Ethnicity: _____ Aboriginal / Torres Strait Islander Origin: □ Yes / □ No

Do you have any specific cultural requirements? _____
Do you speak a language other than English? _____
Do you require an interpreter? □ Yes / □ No Language: _____

Address: _____
Suburb: _____ State: _____ Postcode: _____
Phone (H): _____ (W): _____ (M): _____
Email: _____ Occupation: _____

Medicare No: _____ Position on card: _____ Expiry: _____
Private Health Fund: _____ Member No: _____

□ Pension Card □ DVA □ Health Care / Concession (Type: _____)
Card No: _____ Expiry: _____

□ WorkCover Claim No: _____ Employer: _____ Date of Injury: _____
□ TAC Claim No: _____ Date of Injury: _____
Case Manager's Name: _____ Insurer's Name: _____
Contact Details: (P): _____ (F): _____ (E): _____

General Practitioner: _____ Practice Name: _____
Phone: _____ Address: _____

Referrer: _____ Contact Details: (P): _____ (F): _____ (E): _____

Emergency Contact's Name: _____ Relationship: _____ Phone: _____

How did you hear about us? _____

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**Medical History:**

| | | | |
|---|---|---|---|
| Diabetes | □ Y or □ N | Pituitary Disease | □ Y or □ N |
| Heart Disease | □ Y or □ N | Epilepsy | □ Y or □ N |
| High Blood Pressure | □ Y or □ N | Asthma / Eczema /Hay Fever | □ Y or □ N |
| Blood Clot | □ Y or □ N | Cancer (yourself) | □ Y or □ N |
| (Deep Venous Thrombosis (DVT) or | | Psychiatric Treatment | □ Y or □ N |
| Pulmonary Embolus (PE)) | | Autoimmune Disease | □ Y or □ N |
| Lung Disease | □ Y or □ N | Other Conditions | □ Y or □ N |
| Liver or Kidney Disease | □ Y or □ N | (E.g. Fibromyalgia) | |
| Thyroid Disease | □ Y or □ N | Smoke / Alcohol / Drugs? | □ Y or □ N |

**Other Medical History / Additional Comments:**

_____

_____

_____

_____

_____

**Main Symptom(s) / Complaint(s) For This Review:**

_____

_____

_____

**Spine Imaging Previously Performed (X-Ray, MRI, CT, Others):** □ Y or □ N

**Date(s) of Spine Imaging(s) Previously Performed:** _____

**Name of Radiology Practice(s) Imaging(s) Was/Were Performed:** _____

**Previous Spine Injection(s):** □ Y or □ N

**Date(s) of Previous Spine Injection(s):** _____

**Name of Radiology Practice(s) Injection(s) Was/Were Performed:** _____

**Previous Surgeries (Including Dates):**

_____

_____

**Family History And Genetic Conditions:**

_____

_____

**Allergies / Intolerances (Including Symptoms):**

_____

_____

**Medications / Supplements (Including Dosages):**

_____

_____

_____

_____

_____

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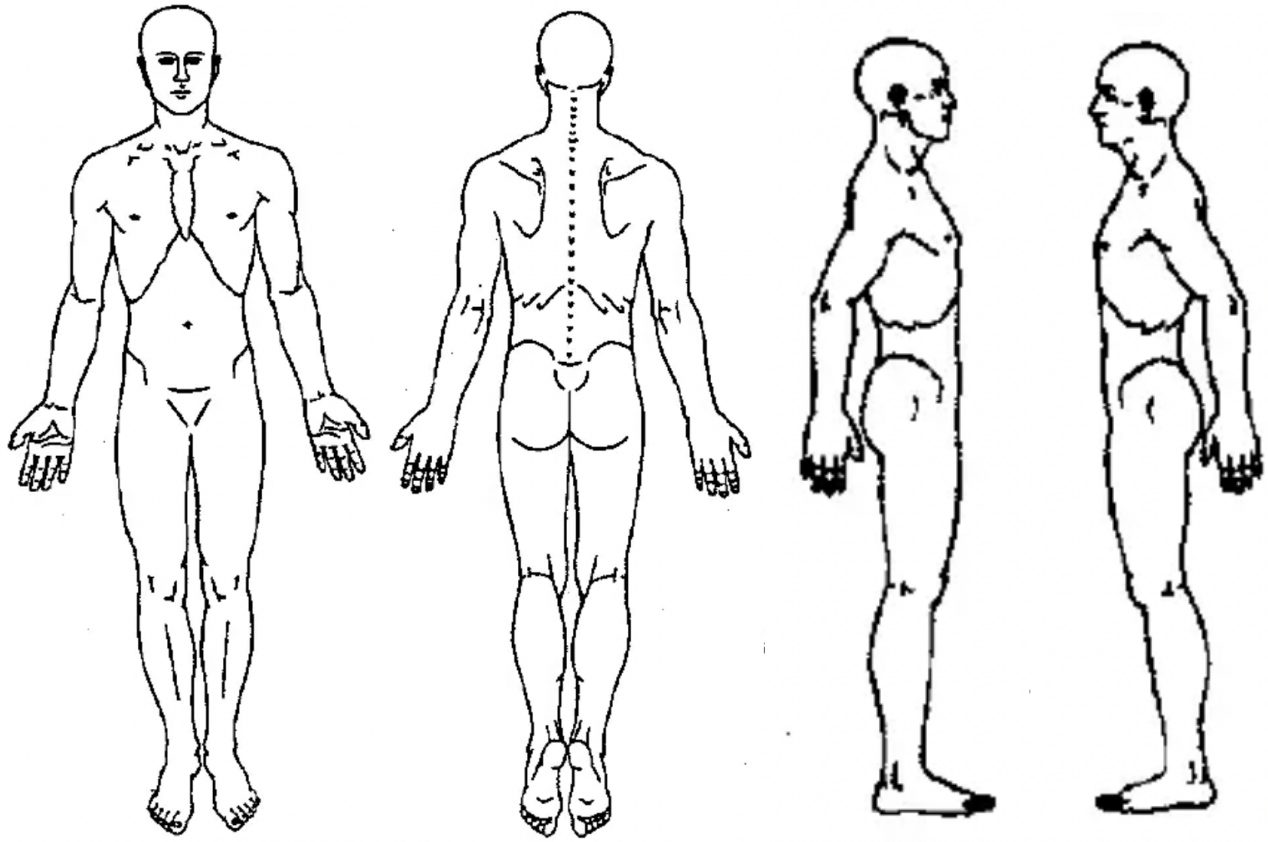
Name: _____ Date: _____

# PAIN DIAGRAM

On the diagrams below, please mark where you are experiencing the symptom(s). Use the various shapes below to indicate the type and location of your sensations.

Ache: xxxxx
Numbness: - - - - -
Pins & Needles: ooooo
Burning: ^^^^^
Stabbing: ⊕⊕⊕⊕⊕
Other (Please specify): sssss



Front Back Right Left

Please describe your symptom(s)/condition(s) further if needed.

## Pain Scale

Please rate the severity of your pain on the following scale.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Worst Possible Pain |

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# Personal & Health Information Consent

We respect your privacy rights and take our privacy obligations seriously. We comply with the Australian Privacy Principles found under the Privacy Act 1988. Our Privacy Policy can be obtained from:

- melbournespinestudio.com.au
- Reception

You consent to Melbourne Spine Studio collecting your personal and health information by signing this form. Please read this information carefully, and sign where indicated below.

Melbourne Spine Studio collects information from you for the primary purpose of providing you with healthcare services. We require you to provide us with your personal and health information, including your complete medical history, so we may provide our services. We will also use the information you provide in the following ways:

- Appropriately manage our practice, such as conducting audits and undertaking accreditation processes, managing billings and training staff;
- Effectively communicate with third parties, including Medicare Australia, Private Health Insurers, government departments and other practitioners involved in your healthcare;
- Data collected from consultations and surgeries will be used for research purposes. All information will be de-identified.

I have read the information above and understand why my data is collected and how it is used. I acknowledge that I am not obliged to provide any information requested but that failure to do so might compromise the quality of care.

Patient Name: _____ Date: _____/_____/_____

Patient signature:

Signed as □ Parent / □ Guardian for _____

Name: _____ Relationship: _____