Wagga Endoscopy Centre
ACN 065 816 408

A Member of
cura
day hospitals group

50 Best Street
WAGGA WAGGA NSW 2650
Phone: (02) 6921 2711
Fax: (02) 6921 2201
www.curagroup.com.au

PATIENT DETAILS

OFFICE USE ONLY **MRN:**

Date:		Allergies:
Specialist:		
Referring Dr/ G.P.		

PATIENT PARTICULARS				
☐ MR ☐ MRS ☐ MISS ☐ MS	Full Name:			
Address:				
Suburb:			Postcode:	
Phone No. Home:	Work:		Mobile:	
Email Address:			**Date of Birth:**	
Country of Birth:		Occupation:		
Marital Status: Married ☐	Never Married ☐	Widowed ☐	Divorced ☐	Separated ☐
Indigenous Origin - Neither Aboriginal/TSI	Aboriginal	TSI	Both Aboriginal and TSI	
Referral Doctor:		Usual Doctor:		

Medicare No: __ __ __ __ __ __ __ __ __ __ __	Ref.No (No. **before** your name): __ Exp Date /
Pension / Heath Care Card No.: __ __ __ - __ __ __ - __ __ __ __	Expiry Date: / /
DVA File No:	Gold ☐ White ☐ Pension ☐

Do you have **Private Hospital Cover**? ☐ YES ☐ NO	Name of Health Fund:
Members Name:	Membership No.:
Full Name (as it appears on card):	Ref No (No. before your name):
Have you had continuous Private Hospital Cover for <u>over</u> 12 months? ☐ YES ☐ NO *(If no, please contact your fund for cover details and eligibility.)*	
Do you have an excess and/or co-payment with your health fund? ☐ YES ☐ NO If yes, how much? Excess: $ ____________________ Co-Payment: $ ____________________	
Have you had an admission to Wagga Endoscopy Centre within the last 28 days? ☐ YES ☐ NO	
Have you had an admission to another hospital in this calendar year? ☐ YES ☐ NO	

Next of kin/contact person:		
Address:		P/Code
Relationship to you:		
Ph No. Home -	Work -	Mobile -

If you supply your work/home phone number, do you authorise our staff to identify ourselves as calling from Dr Fernon/Dr Chow's rooms? ☐ YES ☐ NO (Please tick)

Wagga Endoscopy Centre
ACN 065 816 408

A Member of
cura
day hospitals group

50 Best Street
WAGGA WAGGA NSW 2650
Phone: (02) 6921 2711
Fax: (02) 6921 2201
www.curagroup.com.au

MEDICAL HISTORY

Affix Label Here

PLEASE TICK ANY OF THE FOLLOWING YOU HAVE HAD:

☐	High blood pressure	☐	Fits	☐	Poor Vision
☐	Low blood pressure	☐	Faints	☐	Cancer
☐	Heart disease	☐	Arthritis	☐	Operation for bowel cancer
☐	Chest pain	☐	Gallstones	☐	Operation for cancer (other)
☐	Stroke	☐	Kidney disease	☐	Ulcerative colitis
☐	Parkinson's disease	☐	Diabetes	☐	Family history of bowel cancer
☐	Emphysema	☐	Glaucoma	☐	Family history of colonic polyps
☐	Asthma	☐	Anaemia	☐	Hepatitis A B C
☐	Bronchitis	☐	Persistent bleeding	☐	HIV positive
☐	Persistent cough	☐	Neck or jaw deformity	☐	Advanced care plan
☐	Ulcers	☐	Sleep Apnoea	☐	Fallen in the last 12 months
☐	Tuberculosis	☐	Mouth ulcers		
☐	Epilepsy	☐	False teeth Upper/lower		Female patients:
☐	Migraine	☐	MAO inhibitor drugs		Are you pregnant? ☐ Yes ☐ No
☐	Psychiatric illness	☐	Urinary retention		Are you lactating? ☐ Yes ☐ No

HAVE YOU HAD ANY OTHER SERIOUS ILLNESS? ☐ YES ☐ NO
If YES please describe:______________________________

HAVE YOU HAD ANY OPERATIONS? ☐ YES ☐ NO (Please attach a separate piece of paper if necessary)
If YES please list: ______________________________

DO YOU TAKE ANY MEDICATIONS (Please include prescribed and natural)? ☐ YES ☐ NO
If YES please list: ______________________________

DO YOU HAVE ANY ALLERGIES? ☐YES ☐NO

DO YOU SMOKE ☐ YES ☐ NO

If YES please list: ________________________

When did you last eat or drink: Food__________ ☐am ☐pm Date………… Fluids__________ ☐ am ☐pm Date………..

Who is to drive you home today? Name: ____________________ Telephone No________________
or ________________

- I have read and I understand the attached account information details and agree to abide with the accounting process. I also understand that any out of pocket expenses are to be paid on the day of my procedure.
- I have read, understood and followed all preparation instructions.
- I have disclosed all relevant medication and allergy information.

Signature: ……………………………..