NEW PATIENT REGISTRATION FORM

Welcome to the SOS (Specialist Orthopaedic Surgery) Clinic.
Please fill in this form to help us provide you with the best possible treatment.

Title Mr / Mrs / Ms / Miss **Given Names** ..... **Preferred Name:** .....

Surname .....

Address .....

Suburb ..... **Postcode** .....

Date of Birth ..... / ..... / ..... **Age** ..... **Sex** M / F

Telephone Home ..... **Work** ..... **Mobile** .....

Email Address .....@..... **Occupation** .....

Medicare Card Number ..... **Ref No.** (Number next to your name) .....

Medicare Card Expiry Date ...../.....

Private Health Insurance Fund ..... **Date Joined** ..... **Member number** .....

Pension Card /Health Care Card Number ..... **Expiry Date** .....

Veterans Affairs Care Card Number ..... **Gold Card** Yes / No

REFERRING DOCTOR:
Must be completed
Full name .....

Address .....

FAMILY DOCTOR:
Must be completed
Full name .....

Address .....

TREATING PHYSIOTHERAPIST:

Full Name ..... Clinic Name .....

Address .....

IS THERE ANYONE ELSE YOU WOULD LIKE CORRESPONDENCE SENT TO ?

Full Name ..... Clinic Name .....

Address .....

NEXT OF KIN:

Next of Kin ..... Relationship .....

Home Phone ..... Mobile .....

THIS SECTION IS FOR 'WORKCOVER' CLAIMS ONLY

Date of injury ..... / ..... / ..... **Claim Number** .....

Name of Insurance Company .....

Insurance Company Address .....

Case Manager's Name ..... **Phone Number** .....

Employers Name ..... **Phone Number** .....

Employers Address .....

**** Please note: If any of the details above are not included, requests WILL NOT be sent to Work Cover until all of the details have been given ****

THIS SECTION IS FOR 'TRANSPORT ACCIDENT' CLAIMS ONLY

TAC Date of accident ..... /..... /..... Claim No .....

FEES PAYABLE A referral (within 12 months) from your Local Doctor is required for your Medicare rebate.

INITIAL CONSULTATION $180.00
REVIEW $ 90.00

PRIVACY POLICY

(A) I understand this practice handles personal information in accordance with the National Privacy Principles enshrined in the Privacy Act 1988 (Commonwealth), and as outlined in the Privacy Statement. I consent to the handling of my information by this practice for the purpose of providing quality health care; associated administrative billing purposes and for other treating allied health professionals. I also give permission for medical information to be obtained from any other source in order to assist with my treatment.

(B) I understand my health information will be used for "secondary purposes" such as auditing, monitoring surgical results and clinical research. Record keeping may also include x-rays and images/photographs. I understand the privacy of individuals is strictly maintained when reporting results of audits or research to the profession. I also consent to information, x-rays and images/photographs being used for the secondary purposes of audit and research by the medical staff at the Specialist Orthopaedic Surgery Clinic.

I have read and understood the above Fees Payable Policy.
I have read, understood and consent to the above Privacy Policy, both sections (A) and (B).

Signature _____ **Date** _____

Where did you hear about SOS Clinic: *please circle*

- *Referring Doctor*
- *Physiotherapist*
- *Sports Physician*
- *Family Member / Friend*
- *Internet*
- *Other (please specify)* _____