Specialist Orthopaedic Surgery Clinic

NEW PATIENT REGISTRATION FORM

Welcome to the Specialist Orthopaedic Surgery Clinic.

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 No** ....

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

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

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<u>NEXT OF KIN</u>: **Name** .... **Relationship** ....

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

<u>REFERRING DOCTOR</u>:

Full name ....

Address ....

<u>FAMILY DOCTOR</u>:

Full name ....

Address ....

<u>TREATING PHYSIOTHERAPIST</u>:

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

Address ....

IS THERE ANYONE ELSE YOU WOULD LIKE CORRESPONDENCE SENT TO ?

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

Address ....

Please turn over to complete page 2

SECTION '1' and '2' ARE FOR WORKCOVER and TAC CLAIMS ONLY AND MUST BE FULLY COMPLETED

If any of the details below are not completed, requests CANNOT be sent to WC/TAC until all of the information is provided

Section 1—For WorkCover Patients

Has WorkCover approved your claim *(please tick)* .... □ Yes □ No □ Claim Pending

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

Name of Insurance Company ....

Insurance Company Address ....

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

Email Address .... **Fax Number** ....

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

Employers Address ....

Section 2—For Transport Accident Commission (TAC) Patients

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

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

INITIAL CONSULTATION $ 190.00 / **REVIEW** $ 95.00

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**______________________________

Referral Source — How did you hear about Mr Fary: *(Please tick)*

- □ *Referring Doctor ...... □ GP (or) □ Specialist*
- □ *Physiotherapist*
- □ *Sports Physician*
- □ *Family Member / Friend*
- □ *Website ...... □ www.camdonfary.com.au □ www.sosclinic.com.au □ Internet □ Google*
- □ *Other (please specify)* ....