MR CAMDON FARY
BSc(Hons) MBBCh BAO FRACS(Ortho) FAOrthA
ORTHOPAEDIC SURGEON

NEW PATIENT REGISTRATION FORM

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** .....

Do you have Private Hospital Health Insurance *(please tick)* ☐ **Yes** / ☐ **No**
If yes, are you a Member for more than 12 months *(please tick)* ☐ **Yes** / ☐ **No**

Private Health Insurance Name ..... **Membership No** .....

Medicare Card Number ..... **Your Ref No.** ..... **Valid to** *(date)* .....

Pension Card Number *(if applicable)* ..... **Type of Pension** ..... **Expiry** .....

Veterans Affairs Card Number *(if applicable)* ..... **Card Colour** .....

NEXT OF KIN: Name ..... Relationship .....

Mobile Number ..... Home Number *(if avail)* .....

REFERRING DOCTOR:

Doctor's Name ..... Clinic Name .....

Address .....

FAMILY DOCTOR: *If the referring doctor is different to your family doctor, please complete details below.*

Family Doctor's Name ..... Clinic Name .....

Address .....

TREATING PHYSIOTHERAPIST: **Do you have a treating Physiotherapist ?** ☐ **Yes** / ☐ **No**

Physiotherapist Name ..... Clinic Name .....

Full Address .....

IS THERE ANYONE ELSE YOU WOULD LIKE CORRESPONDENCE SENT TO ?

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

Full Address .....

Please turn over and 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, all sections 'must' be fully completed**

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, all sections 'must' be fully completed**

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

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).

PATIENT SIGNATURE _____ **DATE**_____

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

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