PATIENT INFORMATION FORM

Date completed: ....../....../......

Date revised: ....../....../......

Title:	Given Name:	Surname:
Gender: ☐M ☐F	DOB:	Age:

Address:	State	PCode:
Postal address:	State:	PCode:

Ph (h):	Ph (w):	Mob:	☐ SMS reminders okay
Email:		Occupation:	
Medicare no:	Valid to:	Ref no:	Pension no:
DVA repat no:	Service no:	Rank:	
Referring Doctor:		Usual GP:	
Hospital Cover ☐Y ☐N	Private Health Fund:	Number:	Ref no:
Reason for visit:			

Parent's name (or guardian if under 18):	Parent's DOB:

Emergency contact:	Relationship to you:	Ph:

Please note:
Your consultation is in private rooms.

☑ I understand that full payment for consultation, plasters, bandages, splints, braces etc is required at the time of consultation unless prior, documented arrangements have been made with this office. An account keeping fee for all outstanding accounts may be charged.

For private patients, an invoice/receipt, which can be taken to medicare for rebate, will be issued with your payment. It is not the policy of this practice to bulk bill for services rendered. If you are having difficulties with payment please discuss this with your doctor's rooms prior to your appointment.

☑ I understand that I will only be notified by Canberra Orthopaedics of any clinically relevant pathology results pertaining directly to my surgery.

☑ I give consent for medical information concerning myself or my child to be released to my insurer, employer, solicitor, my referring GP and other health professionals involved in my care.

☑ I give consent to the above information and any other relevant medical information being scanned and stored in my electronic patient file.

☐ I agree to the above conditions **Signed: ....** **Dated: ....**

Is This Consultation Related to a Medico-Legal Issue ☐Yes ☐No

Is This a Workers Compensation or Third Party Claim ☐Yes ☐No

If yes please complete section below

Written approval for consultation is required at the time of consultation otherwise fees will be the responsibility of the patient

Insurance Company:		
Address:		
Phone:	Fax:	Contact person:
Claim no:		Date of injury:
Employer (at time of injury):		
Employer Address:		
Phone:	Fax:	Contact person:
Solicitor:		
Address:		
Phone:	Fax:	Contact person:

Canberra Orthopaedics privacy policy for the management of health information is on display in the reception area for your perusal.