WELLINGTON ORTHOPAEDICS PATIENT REGISTRATION FORM (pg1)

SURNAME: _____FIRST NAME: _____TITLE: _____

ADDRESS: _____

SUBURB: _____POST CODE:_____ DOB:_____/_____/_____

TELEPHONE: (H) _____ (W)_____

MOBILE: _____ **EMAIL:** _____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT (if different from the above OR if patient under age 18):

Name:_____ DOB:_____/_____/_____ Medicare Reference No (eg 2): _____

PATIENT MEDICARE NO: _____ **REFERENCE NO** (no. next to your name): _____

PRIVATE HEALTH YES/NO FUND: _____ MEMBER NO: _____

DATE OF ISSUE:_____/_____/_____ HAVE YOU BEEN A MEMBER FOR MORE THAN 1 YEAR? YES / NO

LEVEL OF COVER: _____

AGED PENSION/DVA CARD NO: _____ EXP:___/____ COLOUR: _____ **TYPE(circle):** Pens/DVA

REFERRING DR: Specialist/GP referral (circle one) - Note: Specialist referrals are valid for 3 months only.

NAME: _____ DATE OF REF:_____/_____/_____

REGULAR GP: (if different to above) _____

If there are any other medical practitioners you would like copies of correspondence sent to, please list:

NAME / ADDRESS / PHONE: _____

_____

Is this a WORK COVER claim? YES / NO **Is this an MAIB claim? YES / NO**

CLAIM NO / MAIB NO: _____ DATE OF INJURY:_____/_____/_____

CASE MANAGER: _____ PH: _____

EMAIL ADDRESS: _____ INSURANCE COMPANY**:** _____

NAME & ADDRESS OF EMPLOYER: _____

_____

Consultation fees are charged above the schedule fee & there will be a gap after claiming from Medicare.

Please complete the back of form....

WELLINGTON ORTHOPAEDICS PATIENT REGISTRATION FORM (pg2)

HEALTH INFORMATION

Diabetes **YES/NO**

_____

ALLERGIES: (please list)

_____

_____

_____

CURRENT MEDICATIONS: (please list)

_____

_____

OTHER IMPORTANT INFORMATION: (if applicable)

_____

_____

_____

Please read ..... IMPORTANT Privacy Policy

From 21/12/2001 the Federal Privacy Act of 1988 has been amended to apply to all doctors in private practice. It is required that a fully informed voluntary consent is obtained before or as soon as practical after the collection of health information. Medical care requires full knowledge of patient health information by all members of a medical team, which may be shared from time to time. This may include referring doctors, pathology, radiology, anaesthetists, Medicare, private health funds and debt collection agencies.

Health information may be used for "secondary purposes" such as auditing surgical results, clinical research etc. Record keeping may also include xrays and photographs. The privacy of individuals is strictly maintained when reporting results of audits or research to the profession.

I (print name) _____have read and understood the above and consent to information, xrays, and photographs being used for the secondary purposes of audit and research by Mr Michael Pritchard and his associates. I also consent to medical records and xrays being destroyed after seven (7) years if I am no longer being treated by Mr Pritchard / associates.

Signed: _____(if guardian, relationship to patient): _____

Date: _____/_____/_____