

**PRITCHARD ORTHOPAEDICS
PATIENT REGISTRATION FORM (pg1)**

SURNAME: _____ FIRST NAME: _____ TITLE: _____

POSTAL ADDRESS: _____

SUBURB: _____ POST CODE: _____ DOB: ____/____/____

HOME PHONE: _____ WORK PHONE: _____

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: _____ **REF NO** (no. next to your name): ____

PRIVATE HEALTH FUND YES/NO (circle) **FUND NAME:** _____

MEMBERSHIP NO: _____ **LEVEL OF COVER:** _____

HAVE YOU BEEN A MEMBER OF YOUR CURRENT FUND FOR MORE THAN 1 YEAR? YES / NO (circle)

AGED PENSION CARD NO: _____ **DVA (Veterans Affairs) No:** _____
COLOUR (please circle): GOLD / WHITE

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 (specialist/physio etc) you would like copies of correspondence sent to, please list:

NAME / ADDRESS / PHONE / EMAIL: _____

Is this a WORK COVER claim? YES / NO (please circle)

Is this an MAIB claim? YES / NO (please circle)

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

CASE MANAGER for insurance: _____ **PH:** _____

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

NAME & ADDRESS OF EMPLOYER: _____

CASE MANAGER FOR EMPLOYER: _____ **PH:** _____

EMAIL: _____

**Consultation fees are charged above the schedule fee & there will be a gap after claiming from Medicare.
Please complete the back of form....**

PRITCHARD ORTHOPAEDICS
PATIENT REGISTRATION FORM (pg2)

HEALTH INFORMATION

DIABETIC: YES / NO (circle) **Type 1 / Type 2** (circle one)

CARDIAC CONDITION: YES / NO (circle) **If YES, Cardiologist Name:** _____

Address: _____

RESPIRATORY CONDITION: YES / NO (circle) **If YES, Respiratory Physician:** _____

Address: _____

ALLERGIES: (please list if NOT included on your referral letter)

CURRENT MEDICATIONS: (please list if not included on your referral letter)

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. We require your written consent to collect or release personal information about you. Please read this information carefully and sign where indicated below.

Medical care requires full knowledge of patient health information by all members of a medical team so that we may properly assess, diagnose and treat you. This information may be shared from time to time to others involved in your care. This may include referring doctors, pathology, radiology, anaesthetists, Medicare, private health funds and debt collection agencies.

Health information may also be used for auditing surgical results and clinical research. 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. No information that can be used to identify you will be included in any publication of the research results.

I (print name) _____ have read and understood the above and consent to information, xrays, and photographs being used for audit and research purposes 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: ____/____/____