St. George SportsMed
Orthopaedics and Sports Medicine

CONFIDENTIAL PATIENT REGISTRATION FORM

TITLE: __________ **PATIENT SURNAME:** _____________________ **GIVEN NAME(S):**____________________________

ADDRESS: ____**PostCode**________________________

Date of Birth: _________________Telephone Hm: ________________Wk:______________Mobile:____________________

Occupation: ___________________________________ Email address: ____

Medicare Number/DVA______________________________________ Expiry: _____________ Line Number (Ref):_________

Pension/Health Care Card No: ____Type:________________________

Health Fund: ____Membership No: _______________________

Area of Treatment/Compliant (eg L Knee):____

If patient under 18 years of age please supply Medicare details and DOB for the Parent/Payer so we can send claim through on line to Medicare

Parent/Guardian's Name: ____

Parent Medicare Number: _____________________ Expiry: ____/____ Line Number (Ref): _______DOB:____/_____/_____

Next of Kin Name: ___________________________________ Next of Kin Relationship: ______________________________

Next of Kin Telephone Number: ______________________

Usual/Family Doctor/GP: _______________________________________ Telephone No: __________________________

Address: ____

Referring Doctor: __________________________________ Telephone No: ____

Address: ____

Physiotherapist: ____

Address: ____ Telephone Number: ____________________

Practice Privacy Policy

This practice is, as a health provider in the private sector, bound by the National Privacy Principles and the Health Records and Information Privacy Act 2002 (NSW). These Principles set the standards by which personal information is collected from patients. A copy of these Principles is available from the Department of Health or the Australian Medical Association.

As part of your treatment, it is usual to write to your referring Doctor, the Physiotherapist involved in your care, and any other Specialists to whom you are referred, including x-rays MRI's etc.

In the case of compensation matters it may be necessary to write to the Insurers, Solicitor, and Employer and/or rehabilitation provider.

As outlined in the above mentioned guidelines, only the necessary information will be released.

For quality assurance and research, information may be extracted from you record and held on a specific secure database on occasions. It may be necessary for us to contact you for ongoing assessment.

Unless otherwise indicated - I HEREBY AUTHORISE THE RELEASE OF MY MEDICAL HISTORY TO MY FAMILY DOCTOR/INSURANCE COMPANY/SOLICITOR (WHERE APPLICABLE) AND TO TAKE RESPONSIBILITY FOR THE PAYMENT OF ALL ACCOUNTS PRIVATE OR INSURANCE.

Signed: ....

Printed Name: .... **Date:** ....

PTO

To Be Completed for Workers Compensation or Third Party Claims

Insurance Company: ____

Address: ____

Phone Number:_____________________Fax Number:___________________Contact Person:_______________________

Claim Number: ____

Employer: ____

Address: ____

Contact Person: ____ Phone: __________________________

Solicitor: ____

Address: ____

Contact Person: ____ Phone: __________________________

Accident Details:

Date: ______________________Place:____

Brief Description:

____

____

____

____

____

Signature: ____Date________________________________

Print Name: ____