TheSpecialistOrthopaedicCentre

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Grafton NSW 2460

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02 66195450
info@specialistortho.net.au

Mr/Mrs/Ms/Miss/Dr Surname: _____ First name: _____

Date of birth:_____ Height: _____ Weight: _____kgs

Residential address: _____

Postal address: _____ *Same as residential address* ☐

Home phone number: _____ Mobile number: _____

Email address: _____

Medicare: _____ IRN (individual reference number): _____ Expiry date: _____

DVA (Department of Veteran Affairs) number: _____Expiry date: _____ Card colour: _____

Private Health Fund Name: _____ Number: _____ Customer no. ____

Pension/Health Care Card Number: _____ Expiry date: _____

Alternative Contact/Next of Kin/Parent Guardian: _____

Phone: _____ Relationship to patient: _____

(Required if patient is <16) - Guardian DOB: _____ *Medicare IRN:* _____

GP / Referring Doctor: _____

Do you see a Cardiologist or other Specialist – please list:

_____

Is this a Work Cover / CTP / Public Liability visit? Please circle one **YES** **NO**

If so, details on separate form, please speak to reception.

Patient consent please read and sign

I give permission for my personal health information to be used for administrative purposes to assist in the running of this practice, including disclosure to others involved in my health care, such as treating doctors and specialists within and outside of this practice. (This may occur through referral to other doctors and specialists, or for medical tests and in the results or reports returned to my referring doctor).

I understand that by signing below that the practice is authorised on my behalf to use my personal health information and I am free to withdraw consent at any time.

SIGNATURE OF PATIENT (or Guardian) _____ **Date:** _____