PATIENT REGISTRATION

My Sports & Joints

Title: Mr Mrs Ms Miss Master Other:_____		Language spoken:		
Preferred name:		Interpreter req'd (circle):	YES	NO
Surname		Given name		
Address:				
Postal code:		Email:		
Date of birth:		Home phone:		
Age:	Mobile:	SMS Contact	YES	NO
Occupation:		Fax:		
Emergency contact name:		Emergency contact number:		

Medicare No.		Ref No.	Expiry:
Parents name and DOB		Parent medicare ref #	
Private Health Fund:		Membership No.	
Level of cover:			
DVA (Veteran's Affairs gold card only):			

GP name & address:
Referring doctor name & address:
Physiotherapist name & address

Workers Compensation and Third Party	
Insurance Company name & address:	
Claim number:	Case Manager:
Case Manager Phone:	Case Manager Fax:
Employer name & address:	
Date of Injury:	Occupation/Position:
Solicitors name & address if applicable	

PATIENT CONSENT AND DECLARATION

I understand and give permission to this medical practice to collect and release information to other medical professionals regarding my personal details and medical history in order to provide healthcare. The information provided may be used for administrative, billing (in compliance with Medicare and Health Insurance Commission requirements), and communication to other health professionals involved with my care. This information may be communicated electronically. My information may be used for medical research, teaching, and audit purposes (all information used will be de-identified in these cases). I understand that it is my responsibility to pay my account costs at time of consultation for surgical and consultation fees. Debt collection services will be utilized at my cost for outstanding fees. In cases of Workers' Compensation or Third-Party claim where the claim is declined it is my responsibility to pay the fees involved with my care.

Signature (Patient/Parent/Guardian):_____________________________________ Date:________________

Name (Please Print) ____