

Dr Alan Dao FRACS (Ortho), FA(Orth)A, MBBS, BaAppSc(Phty)

Upper limb, Sports, Arthroplasty, Trauma

Dr Arnold Suzuki FRACS (Ortho), FA(Orth)A, MBBS, BSc, BEd

Lower limb, Arthroplasty, Sports, Paediatrics, Trauma



PATIENT REGISTRATION FORM									
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:				
Self funded					YES		NO		
Medicare No.					Ref No.		Expiry:		
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) _____