

PATIENT INFORMATION

Dr/Mr/Mrs/Ms/Miss/Mstr

SURNAME: _____ GIVEN NAME(S): _____

DATE OF BIRTH: ____/____/____ OCCUPATION: _____

ADDRESS: _____ Post Code : _____

EMAIL ADDRESS: _____

TELEPHONE: HOME: _____ MOBILE: _____

PERSON RESPONSIBLE FOR ACCOUNT: (Parent or Guardian) _____

NEXT OF KIN: (Name & Phone Number) _____

REFERRING DOCTOR: _____

FAMILY DOCTOR : (if different to above) _____

PHYSIOTHERAPIST : (name and location) _____

MEDICARE NUMBER: _____ Reference Number : _____

PRIVATE HEALTH FUND: _____ Membership Number : _____

WORKCOVER or TAC:

CLAIM NUMBER: _____ DATE OF INJURY: _____

INSURER (e.g. Allianz, CGU) : _____

MEDICAL CONDITIONS / RECENT SURGERY :

CURRENT MEDICATION (Include Blood Thinners or Aspirin) :

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: _____

FEES : New Consultation \$250.00 ; Subsequent Consultations \$120 ; WorkCover and TAC First Attendance \$300.00

CONSENT : I consent to the confidential handling of this information and to abide by the payment terms of this practice.

SIGNED: _____ DATE: _____

ASSOCIATES:

MARK BLACKNEY
FOOT & ANKLE

TERENCE CHIN
FOOT & ANKLE

ROBERT HOWELLS
KNEE, HIP & SHOULDER

CHRIS KONDOGIANNIS
KNEE & HIP

HAYDEN MORRIS
KNEE

GERALD QUAN
SPINE

JOHN SALMON
SHOULDER & ELBOW

NATHAN WHITE
KNEE