RICHARD DALLALANA
SHOULDER & ELBOW SURGEON
MBBS FRACS FAOrthA

Park Clinic
ORTHOPAEDICS

Level 7 166 Gipps Street
East Melbourne VIC 3002
T (03) 8415 1907
F (03) 8415 0132
E dallar@parkclinic.com.au
W www.parkclinic.com.au

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.
I consent to the use of de-identified clinical and operative images for the purpose of research, teaching and case discussion

SIGNED: ______________________ DATE: ______________________