

### 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: \_\_\_\_\_

**ASSOCIATES:**

MARK BLACKNEY  
FOOT & ANKLE

TERENCE CHIN  
FOOT & ANKLE

ROBERT HOWELLS  
KNEE, HIP & SHOULDER

HAYDEN MORRIS  
KNEE

GERALD QUAN  
SPINE

JOHN SALMON  
SHOULDER & ELBOW

NATHAN WHITE  
KNEE