WELLINGTON ORTHOPAEDICS (PRITCHARD / WILKINSON)
PATIENT REGISTRATION FORM (pg1)

SURNAME: ______________________ FIRST NAME: ______________________ TITLE: __________

POSTAL ADDRESS: ____

SUBURB: ______________________ POST CODE: ______________ DOB: _____/_____/_____

HOME PHONE: ______________________ WORK PHONE: ______________________

MOBILE: ______________________ **EMAIL:** ______________________

NAME OF PERSON RESPONSIBLE FOR ACCOUNT (if different from the above OR if patient under age 18):

Name: ______________________ DOB: _____/_____/_____ Medicare Reference No (eg 2): ___

PATIENT MEDICARE NO: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **REF NO** (no. next to your name): ___

PRIVATE HEALTH FUND YES/NO (circle) FUND NAME: ______________________

MEMBERSHIP NO: ______________________ LEVEL OF COVER: ______________________

HAVE YOU BEEN A MEMBER OF YOUR CURRENT FUND FOR MORE THAN 1 YEAR? YES / NO (circle)

AGED PENSION CARD NO: ______________________ **DVA (Veterans Affairs) No:** ______________________

COLOUR (please circle): GOLD / WHITE

REFERRING DR: Specialist/GP referral (circle one) - Note: Specialist referrals are valid for 3 months only.

NAME: ______________________ DATE OF REF: _____/_____/_____

REGULAR GP: (if different to above) ______________________

If there are any other medical practitioners (specialist/physio etc) you would like copies of correspondence sent to, please list:

NAME / ADDRESS / PHONE / EMAIL: ______________________

____

Is this a WORK COVER claim? YES / NO (please circle) **Is this an MAIB claim? YES / NO (please circle)**

CLAIM NO / MAIB NO: ______________________ **DATE OF INJURY:** _____/_____/_____

CASE MANAGER for insurance: ______________________ PH: ______________

EMAIL ADDRESS: ______________________ **INSURANCE COMPANY:** ______________________

NAME & ADDRESS OF EMPLOYER: ______________________

____

CASE MANAGER FOR EMPLOYER: ______________________ PH: ______________

EMAIL: ______________________

Consultation fees are charged above the schedule fee & there will be a gap after claiming from Medicare.

Please complete the back of form....

WELLINGTON ORTHOPAEDICS (PRITCHARD / WILKINSON)
PATIENT REGISTRATION FORM (pg2)

HEALTH INFORMATION

DIABETIC: YES / NO (circle) **Type 1 / Type 2** (circle one)

CARDIAC CONDITION: YES / NO (circle) **If YES, Cardiologist Name:** ______________________________

Address: ____

RESPIRATORY CONDITION: YES / NO (circle) **If YES, Respiratory Physician:** _________________________

Address: ____

ALLERGIES: (please list if NOT included on your referral letter)

____

____

CURRENT MEDICATIONS: (please list if not included on your referral letter)

____

____

OTHER IMPORTANT INFORMATION: (if applicable)

____

____

Please read .... IMPORTANT Privacy Policy

From 21/12/2001 the Federal Privacy Act of 1988 has been amended to apply to all doctors in private practice. We require your written consent to collect or release personal information about you. Please read this information carefully and sign where indicated below.

Medical care requires full knowledge of patient health information by all members of a medical team so that we may properly assess, diagnose and treat you. This information may be shared from time to time to others involved in your care. This may include referring doctors, pathology, radiology, anaesthetists, Medicare, private health funds and debt collection agencies.

Health information may also be used for auditing surgical results and clinical research. Record keeping may also include xrays and photographs. The privacy of individuals is strictly maintained when reporting results of audits or research to the profession. No information that can be used to identify you will be included in any publication of the research results.

I (print name) ______________________________ have read and understood the above and consent to information, xrays, and photographs being used for audit and research purposes by Mr Michael Pritchard and his associates. I also consent to medical records and xrays being destroyed after seven (7) years if I am no longer being treated by Mr Pritchard / associates.

Signed: ___________________________ (if guardian, relationship to patient): ____________________

Date: ______/______/______