Patient Registration Form

Please complete both sides & return to staff, thank you

Your Details

Title: ☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Dr** ☐ **Other** _____ **Date of Birth:** ___/___/___

First Name: _____ **Surname:** _____ **Preferred Name:** _____

Street Address: _____

Suburb: _____ **Post Code:** _____

Postal Address *(if different from above)* _____

Email address: _____@_____

Occupation: _____ Height: _____ Weight: _____ Dominant Hand _____

Contact numbers: Home: _____ Mobile: _____ Work: _____

Next of Kin: _____ Relationship: _____ Contact No: _____

Claim Details

(please complete all relevant sections)

Medicare: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ **Ref No:** _____ **Exp:** ____/_____

Private Health Insurer: _____

Member No: _____ Ref No: _____

Veterans Affairs/Pension/HCC Card No: ____ ____ ____ ____ ____ ____ ____ ____ ☐ **Gold** ☐ **White**

WorkCover/TAC Details:

Employer: _____

Date of Accident: _____ / _____ / _____ Insurer: _____

Claim No. _____

Case Manager: _____

Contact No: _____ Fax No: _____

Email: _____@_____

Referral Details *(correspondence will be forwarded to any professionals listed to ensure continuity in your care)*

Referring Doctor: _____ Tel: _____

Clinic Name: _____

Usual GP: *(if different from above)* _____ Tel: _____

Clinic Name: _____

Physiotherapist/Allied Health Professional/Other Specialists names and contact details:

_____

_____

How did you hear about Mr Austin Vo and MSK?

☐ **Referring Doctor** ☐ **Google search** ☐ **Website**

☐ **Physio/Allied Health from** ☐ **Personal recommendation from** ☐ **Other** *(please state)*

_____ _____ _____

Medical Questionnaire *(please tick box and expand on any relevant conditions)*

☐ **Have you tested positive for COVID-19? If so, please list the date** _____/_____/_____

☐ **Smoker** ☐ **Lung Disease** ☐ **Diabetes**

☐ **Heart Disease** *(cardiac failure, AMI, etc)* ☐ **DVT/PE** ☐ **Kidney Disease**

☐ **Allergies** *(please state)*

_____

☐ **Other Medical Conditions/Previous surgery, admissions, or serious illnesses (including year)**

_____

_____

_____

☐ **Have you had any sleep studies or been diagnosed with Obstructive Sleep Apnoea?**

☐ **Are you on any blood thinning medication? E.g., aspirin, apixaban (Eliquis), rivaroxaban (Xarelto), warfarin, etc.**

☐ **Are you on any medication for diabetes?**

Medications Please list all medications, especially blood thinners, diabetic, blood pressure medication etc.	

Please read carefully and sign below:

From December 21, 2001, the Federal Privacy Act of 1988 was amended to apply to all doctors in private practice. It is required a fully informed voluntary consent is obtained before or as soon as practical after the collection of health information. Medical care requires a full knowledge of patient health information by all members of a medical team, which may be shared from time to time, including by electronic means. This may include referring doctors, pathology, radiology, anaesthetists, Medicare, private health funds and debt collection agencies. Health information may be used for 'secondary purposes' such as auditing surgical results, clinical research, etc. Record keeping may also include medical imaging and photographs. The privacy of individuals is strictly maintained when reporting results of audits or research to the profession.

I (print name) _____ have read and understood the above, and consent to information, medical imaging and photographs being used for the secondary purpose of audit and research by Melbourne Shoulder & Knee, their providers and associates. I also consent to medical records and medical imaging being destroyed after seven years if I am no longer being treated by providers at Melbourne Shoulder & Knee.

I understand consultation fees for all patients, including WorkCover/TAC, are required to be paid in full at the time of the appointment. I understand these fees are above the Medicare Benefits Scheme (MBS) fee. I understand the MBS benefit from Medicare can be claimed with the receipt issued if there is a **valid GP/Specialist referral**. I understand that Melbourne Shoulder & Knee does not re-direct accounts and, if I am a WorkCover/TAC patient, I will need to claim from the applicable party with the receipt issued myself.

Signed:_____ Date: _____

If guardian, relationship to patient: _____