Patient Information Form

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Title (please circle): Mr Mrs Ms Miss

First name: _____ **Surname:** _____

Date of Birth: _____ / _____ / _____ **Gender:** Male Female Other

Address: _____

Preferred Contact Phone No: _____ **Other Phone No:** _____

Email: _____ **Occupation:** _____

Are you happy to receive appointment confirmation by SMS: YES / NO

Medicare No: _____ **Card Reference:** _____ **Expiry:** _____ / _____ / _____

Private Health Fund: _____ **Membership No:** _____

DVA Card No: _____ **Colour:** _____

EP ID No: _____ **DAN No:** _____

Referring GP: _____ **Usual GP:** _____

Usual Physiotherapist: _____

IF UNDER 18, PLEASE FILL IN THE FOLLOWING:

Parent responsible for account: _____

Parent Medicare No: _____ **Parent DOB:** _____ / _____ / _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Is this consultation related to Workers Compensation/Third Party Claim? YES / NO

Name of Insurer: _____ **Claim No:** _____

Date of Injury: _____ / _____ / _____ **Contact Person:** _____

Email or Fax: _____ **Phone No:** _____

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TERMS AND CONDITIONS

I agree that the above information may be entered & stored in my electronic patient file and stored at in.motion Orthopaedics

I agree that full payment will be made for the consultation and any consumables at the time of consultation

I agree that my de-identified data may be used for research and audit purposes

I agree to be notified of only clinically relevant pathology or imaging results pertaining directly to my reason for this consultation

I agree that any medical information relating to my consultations may be released to my referring GP and other health professionals involved in my care and my insurer

Signature: _____

Print Name: _____ **Date:** _____ / _____ / _____

A Privacy Policy for the management of your health information at in.motion Orthopaedics is available on request or at inmotionortho.com.au.