CONFIDENTIAL

DR BIJOY THOMAS
Orthopaedic Surgeon

PERSONAL DETAILS

Dr Mr Mrs Ms Miss Surname: _____ **First Names:** _____

Address: _____

_____ **Postcode:** _____

Date of Birth: _____ **Age:** _____ **Occupation:** _____

Phone - Home: _____ **Work:** _____ **Mobile:** _____

Email:_____

Emergency contact: Name: _____ **Phone:** _____

Their relationship to you:_____ **(eg. Parent, partner, child)**

CONDITION TO BE TREATED: Left/Right - Hip/Knee – Please circle

Or other condition: _____

REFERRAL DETAILS:

Referring Doctor: _____ **Referral Date:** _____

Regular Family Doctor (GP): _____

Address: _____

_____ **Postcode:** _____

Do you wish for your regular doctor to be kept informed of your treatment: **YES / NO**

PHYSIOTHERAPIST: _____

MEDICARE/ PRIVATE HEALTH FUND DETAILS:

Medicare No: _ _ _ _ _ _ _ _ _ _ **Your position on card:** _ _ **Valid to:** _ _ / _ _

Private Health Insurance Fund: _____

Membership No: _____ **Have you been with fund for over 12 months? YES / NO**

Level of cover: TOP (GOLD) / MID (SILVER) / BASIC PLUS (BRONZE) / BASIC / EXTRAS ONLY

Veterans' Affairs No: _____ **Gold/White**

WORKERS COMPENSATION/THIRD PARTY DETAILS (IF APPLICABLE)

Employer's Name: ……...……...…….
Insurance Company Name: ……...……
Claim No: ……..…… Date of Injury: ……...……...…….
Case Manager name & phone: ……
I acknowledge that my medical details may be released to my insurer. YES/NO

The above information is correct to the best of my knowledge. I hereby give my consent for medical information concerning myself to be supplied to my referring Doctor/GP/Insurance or other parties as requested and approved. I also accept that in the event of any dispute, the account rendered becomes the responsibility of the patient (or guardian).

Patient Signature _____ **Date** _____