1) Fill in the form by tabbing between fields
2) Then 'save as' (and print if you wish)
3) Finally email to keith.holt@perthortho.com.au

Save As Print

PATIENT INFORMATION SHEET

Dr ☐ Mr ☐ Mrs ☐

Miss ☐ Ms ☐ Other: .....

Last name: .....

First names: .....

Preferred name: .....

Date of birth: .....

Occupation: .....

Address for account:

.....

.....

.....

Post code: .....

Home phone number: .....

Work phone number: .....

Mobile phone number: .....

Email: .....

Home Address: As Above ☐

.....

.....

.....

Post code: .....

Medicare Number:

☐☐☐☐ ☐☐☐☐☐ ☐

The number next to your name on your medicare card (the reference number) → ☐

Expiry date: .....

Private health insurance? Yes ☐ No ☐

HBF ☐ MBP ☐ HIF ☐

Other: ..... Gap Cover .... Yes ☐

Private Fund No: .....

Do you have a pension or health care card?

Yes ☐ No ☐

PHB No: .....

Medical Details

Referring doctor: .....

Suburb: .....

Family doctor: .....

Suburb: .....

Have you been in hospital outside of W.A. in the last 12 months? Yes ☐ No ☐

Have you ever had hepatitis? Yes ☐ No ☐

If yes: Type A (infectious) .. ☐ Type B ..... ☐

Type C ..... ☐ Other: .....

List medical allergies, if any:

.....

.....

Declaration - to be signed by all patients

I, the above patient, hereby consent to the collection and use of this information, and all further information requested by, and given to, staff of Perth Orthopaedic and Sports Medicine Centre, during this and all subsequent consultations, where it will help to provide an accurate medical diagnosis, and to facilitate appropriate treatment, including correspondence to my referring / family doctor.

Signature: ..... Date: .....

(Entering your name here will act as your signature)

Worker's Comp. / Motor Vehicle Accident

Date of accident: .....

Claim Number: .....

Employer: .....

Employer's Insurance Co: .....

Declaration: - to be signed by all patients with workers compensation or motor vehicle claims.

I, ...

agree to be personally responsible for payment of all accounts incurred by me, in the event that liability is denied, or placed in dispute, by the Workers' Compensation Insurance or by the Motor Vehicle Accident Insurance.

Signature: .....

(Entering your name here will act as your signature)