Patient Registration Form

Please return completed form to reception. Thank you.

ARTHRO health

Personal Details

Title: ◯ Mr ◯ Mrs ◯ Ms ◯ Dr ◯ Other: _____ **Date of Birth:** _____

First Name: _____ **Surname:** _____

Street Address: _____

Suburb: _____ **Postcode:** _____

Postal Address (if different from above):

_____

E-mail Address: _____

Occupation: _____

Home: _____ Work: _____ Mobile: _____

Next of Kin, Name (relationship): _____ Contact No: _____

Claim Details

Please complete all that apply:

☐ **Medicare Number:** _____ Ref Number: _____ Expiry: _____

☐ **Private Health Insurance:** _____

Member Number: _____ Ref Number: _____

☐ **Veterans' Affairs Card Number:** _____ Colour: ◯ White ◯ Gold

☐ **WorkCover/TAC Details**

Date of Accident: _____ Claim Number: _____

Insurer: _____ Case Manager: _____

Contact Number: _____ Fax: _____

Referral Details

Please provide details of the following professionals for us to forward correspondence:

Referring Doctor: _____

Address & Tel: _____

Usual Family Doctor (if different from above): _____

Address & Tel: _____

Usual Physiotherapist/Allied Health Professional: _____

Address & Tel: _____

Please turn over

Referral Source

How did you hear about ARTHRO Health and our providers?

Website: _____

Personal recommendation: _____

Other: _____

Medical Questionnaire

Please mark and provide details for all that apply:

☐ Smoker: _____

☐ Allergies: _____

☐ DVT/PE: _____

☐ Heart Disease (eg. AMI, cardiac failure): _____

☐ Lung Disease: _____

☐ Diabetes: _____

☐ Kidney Disease: _____

Other Medical Conditions:

Current Medications (please list):

Previous Operations, Admissions to Hospital or Serious Illnesses (please list including date/year):

Privacy Policy

From December 21, 2001, the Federal Privacy Act of 1988 was amended to apply to all doctors in private practice. It is required that a fully informed voluntary consent is obtained before or as soon as practical after the collection of health information. Medical care requires 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 purposes of audit and research by ARTHRO Health, 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 at ARTHRO Health by their providers.

Signed: _____ Date: _____

If guardian, relationship to patient: _____

Consultation fees (for all patients including WorkCover/TAC) are expected to be paid in full at the time of your appointment. These fees are above the Medicare Benefits Schedule (MBS) Fee. You will be able to claim the MBS benefit from Medicare with the receipt issued if you have a **valid GP/Specialist referral**. All WorkCover/TAC patients will need to claim from the applicable party with the receipt issued.

Please return the completed form to reception. Thank you.