CONFIDENTIAL

DR BIJOY THOMAS
Orthopaedic Surgeon

PERSONAL DETAILS – PATIENT 15 YEARS AND UNDER

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

Address: _____

_____ **Postcode**: _____

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

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

Email:_____

CONDITION TO BE TREATED: Left/Right - Hip/Knee – Please circle joint to be treated

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: _ _ _ _ _ _ _ _ _ _ **Valid to:** _ _ / _ _ **Your position on card:** _ _

Private Health Insurance Name: _____

Membership No: _____

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

PARENT/GUARDIAN : Surname: _____ **First Name:** _____

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

Same Medicare card as patient? YES / NO **Your position on Medicare card:** _ _

Ultimately the patient (or his/her guardian) is responsible for the account. In the unlikely event that payment is overdue by more than 90 days and we have tried to recover the payment by sending reminder notices, we may give information about you to a credit reporting agency. This information is limited to your name, sex, address, date of birth, the amount that is overdue and notification that the payment is no longer overdue (when applicable).

I hereby give my consent for medical information concerning myself or my child to be supplied to my referring Doctor/Employer/Insurance Co/Solicitor or any 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 his/her guardian)

Patient (or Guardian) Signature _____ **Date** _____