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 _____

CONDITION TO BE TREATED:

Left/Right - Hip/Knee – Please circle joint to be treated

Other condition: _____

REFERRAL DETAILS:

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

Regular Family Doctor (**if different from referring doctor**): _____

Address: _____

_____ **Postcode**: _____ **Phone No.**: _____

Do you wish 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: _____ Your position on card: _____

Veteran Affairs No: _____

WORKERS COMPENSATION/THIRD PARTY DETAILS (IF APPLICABLE)

Employer's Name: ……..……..……
Address: ……..……
Insurer's Name: ……..……
Address: ……..……
Claim No: …… Date of Injury: ……..……..…….
Solicitor's Name: ……
I acknowledge that my medical details may be released to my employer/insurer/solicitor. YES/NO

In some circumstances your Workers Compensation Insurer will not pay the entire amount billed by us for your consultation/operation/procedure. In these circumstances, we will send an account to you or your Employer for the balance of your account.

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/Guardian's signature _____ **Dated** _____