PROFESSOR RICHARD CAREY SMITH

PERTH ORTHOPAEDIC AND SPORTS MEDICINE CENTRE

PATIENT DETAILS
Dr / Mr / Mrs / Ms / Miss / Other (circle one)

First name:_____ Surname: _____ Date of birth: ____/_____/____

Address: _____

Phone home: _____ Mobile:_____

Email: _____

Medicare no: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Number in front of your name: ____ Expiry: __ __/ __ __

GUARDIAN INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE:

Full name: _____Date of Birth: ____/_____/____ Medicare no: _ _ _ _ _ _ _ _ _ _ Ref No: _

PRIVATE HEALTH INSURANCE

Do you have private health insurance with HOSPITAL cover? Yes / no (circle one)

Name of fund: _____ Membership number: _____

DEPARTMENT OF VETERANS AFFAIRS

Card number: _____ Gold card / White card (CIRCLE ONE)

NEXT OF KIN DETAILS

Next of kin name: _____ Contact number: _____

REFERRAL DETAILS:

Referring doctor's name: _____ GP Clinic name: _____

Address: _____

OTHER MEDICAL PROFESSIONALS INVOLVED IN YOUR CARE (Cardiologist, Physiotherapist, Oncologist, Rheumatologist, Respiratory specialist etc?)

Usual GP name: _____ GP Clinic name: _____

Address: _____

Physiotherapist name: _____ Clinic name: _____

Contact Number: _____ Email: _____

Other: _____

I provide my consent for Prof Richard Carey Smith and his medical staff to collect, use and disclose my personal information as required by the Privacy Act 1988 and consent for Prof Richard Carey Smith and his medical staff to collect, use, transfer and store clinical images and medical records for the purposes of my clinical care. For unpaid accounts and multidisciplinary meetings, costs will be put through to Medicare on your behalf.

SIGNED: _____ **DATED:** _____

THIS PAGE IS FOR WORKERS COMPENSATION AND MOTOR VEHICLE ACCIDENTS

WORKERS' COMPENSATION & MOTOR VEHICLE ACCIDENT CLAIMS

WORKERS' COMPENSATION INJURY:

Name of Employer: _____

Address of Employer: _____

Contact Number: _____

Email: _____

Date of Accident: _____

Employer's Insurance Company: _____

Workers' Comp Claim Number: _____

Case Manager Name and Contact: _____

MOTOR VEHICLE ACCIDENT:

Date of Accident: _____

Claim Number: _____

Case Manager Name and Contact: _____

IF YOUR CLAIM IS NOT ACCEPTED BY THE INSURANCE COMPANY, YOU WILL BE LIABLE FOR ANY EXPENSES INCURRED DURING THE COURSE OF YOUR MEDICAL CARE

PLEASE SIGN TO ACCEPT THIS ACKNOWLEDGEMENT

SIGNED: _____ **DATED: _____**