

Patient Information Form

Title: _____ First Name: _____ Surname: _____

Known As: _____ Date of Birth: ____/____/____

Address: _____

Preferred Phone No: _____ Alternative Phone No: _____

Gender: ____ Email: _____ Occupation: _____

Appointment Confirmation by SMS OK? Yes/No

Medicare No: _____ Ref # on card: ____ Expiry Date: ____/____/____

Private Health Fund _____ Membership No: _____

DVA card colour: _____ DVA Card Number _____

Military PM Keys No: _____

Occupation: _____

Referring Doctor: _____ Usual GP: _____

Usual Physio: _____

If under 18 Parent/Guardian Responsible for Account: _____

Preferred Phone No: _____

Next of kin: _____ Relationship: _____ Phone No: _____

Is this consultation related to a third party or workers compensation claim? Yes/No

Name of Insurer: _____ Claim No: _____

Date of injury: _____ Contact person: _____

Phone No: _____ Fax No: _____

- ☐ I agree that the above information may be entered and stored in my electronic patient file and stored at CANBERRA KNEE CLINIC.
- ☐ I agree that full payment will be made for the consultation and consumables at the time of consultation.
- ☐ I agree that my de-identified data may be used for research and audit purposes.
- ☐ I agree to be notified of only clinically relevant pathology or imaging results pertaining directly to my reason for this consultation.
- ☐ I agree that any medical information relating to my consultations may be released to my referring GP and other health professionals involved in my care and my insurer.

Signature: _____ Print Name: _____ Date: ____/____/____

A Privacy Policy for the management of your health information at CANBERRA KNEE CLINIC is available on request or on the website www.canberrakneeclinic.com.au