COASTAL ORTHOPAEDIC GROUP PTY LTD

PATIENT REGISTRATION (Please complete 2 PAGES and sign)

MR/MRS/MISS/MS/DR *(Please circle)* SURNAME: ______________________________

GIVEN NAMES: ______________________________ DATE OF BIRTH _____/_____/______

ADDRESS: ____

SUBURB:______________________________ POST CODE: ______________

HOME PHONE: ______________WORK: ______________ MOBILE: ______________

EMAIL ADDRESS: ____

OCCUPATION: ____

Medicare Card No.											Reference No. (next to name)	

PRIVATE HEALTH INSURANCE - YES/NO *(Please circle)*

FUND NAME: ______________________ MEMBER NUMBER: ______________________

Please complete appropriate field if you are on a:

PENSION CARD NUMBER ______________________ EXPIRY _____/_____/______

VETERANS AFFAIRS CARD No. ______________ COLOUR ____________ EXPIRY ____/_____

REFERRING DOCTOR ______________________PRACTICE/SUBURB: ______________

USUAL GP ______________________PRACTICE/SUBURB: ______________
(if different from referring doctor)

PHYSIOTHERAPIST ______________________PRACTICE/SUBURB ______________

NEXT OF KIN DETAILS

NAME ______________________________ PHONE ______________________

RELATIONSHIP TO PATIENT ______________

INJURED BODY PART: (right/left) ______________________

DATE OF INJURY ______________ DURATION of SYMPTOMS ______________

CURRENT DIAGNOSIS: ______________________________

TREATMENT SO FAR:

RECENT RADIOLOGY:

XRAY (which provider): (date):

MRI (which provider): (date):

Ultrasound (which provider): (date):

CT: (which provider): (date):

Other: (which provider): (date):

CONTINUE ONTO PAGE 2

PREVIOUS ORTHOPEDIC SURGERY: *(complete below)*

BODY PART	OPERATION	SURGEON	DATE
-	-	-	-
-	-	-	-

PREVIOUS MEDICAL HISTORY: *(complete below)*

ISSUE	MEDICATIONS
-	-
-	-
-	-

SMOKER: *(please circle)* YES/NO/EX *(how many years)*

DRUG ALLERGIES

-

COMPLETE ONLY IF WORKERS COMPENSATION OR MOTOR VEHICLE ACCIDENT

DATE OF INJURY/ACCIDENT: _____/_____/_____TYPE OF INJURY: ___________________________

HOW DID THE INJURY OCCUR: ____

NAME OF INSURANCE COMPANY ______________________ CLAIM NUMBER: _______________

OCCUPATION ____________________________________

EMPLOYER: __________________________________ PHONE: ______________________________

ADDRESS ____

SUBURB ___________________________POST CODE: _____________

NAME OF SOLICITOR (if any) ___________________________________

ALL PATIENTS please sign:

I, _______________________________________ authorise the release of Clinical information and Reports relating to my condition as treated by Coastal Orthopaedic Group. In the event that my claim is rejected I accept that it is my responsibility for settling all accounts with Coastal Orthopaedic Group.

Signed: _____________________________________ Date: _______/_______/_______

PLEASE SCAN/EMAIL THIS COMPLETED FORM TO info@coastalorthopaedics.com.au prior to your appointment. A picture taken with your smart phone and emailed is fine. If either of these are difficult please bring your form with you to your appointment.