**NEW PATIENT DETAILS**

Mr / Mrs / Miss / Ms Marital Status \_\_\_\_\_\_\_\_ Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Given Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode \_\_\_\_\_\_\_\_\_\_

Postal address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode \_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aboriginal Torres Strait Islander

Tel Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next Of Kin: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Usual Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you seeing any other Specialist or Physician? YES / NO If so who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you seeing a Physiotherapist? YES/NO If so who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have x-rays NO / YES Which x-ray department were they taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you responsible for payment of this account? YES/NO If no, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES?** YES / NO Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LATEX ALLERGY**: YES/NO

**DIABETIC?** YES/NO **INSULIN DEPENDENT?** YES/NO

**MEDICATION:** Are you currently taking any of the following medication:

Warfarin Yes/No Aspirin Yes/No

Clopidogrel – Plavix Yes/No Prednisolone Yes/No

- Xarelto Yes/No Methotrexate Yes/No

Anti-inflammatories (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR HEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_ **YOUR WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICARE DETAILS** Medicare Card No \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

Ref: \_\_\_\_\_ (number to the left of patient name) Medicare Card Expiry Date \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

**PRIVATE HEALTH FUND** YES/NO Covered for PRIVATE OR PUBLIC Covered for more than 12 months YES/NO

Name of Fund \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Membership No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## VETERAN’S AFFAIRS Card No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PENSION/HEALTH CARE CARD NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXP: \_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE TURN OVER AND COMPLETE PAGE TWO**

**PLEASE READ THE PRIVACY STATEMENT AND SIGN WHERE INDICATED**

**PRIVACY STATEMENT**

BallaratOSM Pty Ltd and staff are committed to the protection of your privacy. We require you to provide your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means that we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.

- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

- Disclosure to others involved in your health care, through treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.

- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. (Individuals are **not** identified in these circumstances.)

- X-rays and de-identified clinical photographs may be used for teaching purposes.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

*I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on the handling of patient information.*

*I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.*

*I understand that if my information is to be used for any other purpose other than that set out above, my further consent will be obtained.*

*I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.*

I have read the Privacy Statement and consent to the conditions.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCOUNT INFORMATION

* Consultation costs must be paid on the day.
* Costs incurred in relation to the fitting of a Vacoped boot or Vacocast, additional liner or even up are payable on the day. Reimbursement may be sought from your Health Insurance provider (through your extras cover), Department of Veterans Affairs, Employer, Workcover Insurer or the TAC
* Extra costs for surgery must be paid prior to the date of surgery.
* Any account that remains unpaid for a period of 90 days will result in the denial of any future appointment being made within the practice.
* Any costs involved in recovering outstanding accounts will be the responsibility of the patient.

We at BallaratOSM Pty Ltd are always aiming to improve our services we provide to you.

To help us could you please fill in the brief question below.

**Why did you chose to come to Ballarat Orthopaedics and Sports Medicine?**

GP recommended Google

Sports Physician Hospital/Emergency dept

Recommended by friend or family Word of Mouth

Website Physiotherapist

Other Please specify………………………………………………………………………………………………