DAMIANI ORTHOPAEDICS PATIENT INFORMATION FORM

Title/Rank……..Surname……First Name……..DOB……/……/……../Age……

Address……State……..Post Code……..

Postal Address……State……Post Code……..

Phone (H)……Mobile……Alt Phone……

Medicare NO……..Expiry Date……/…….Reference Number……..

DVA Number…… Gold/White (please circle) Service Number……

Occupation……Email……

Referring Doctor……GP……

Private Health Fund……..Number……...Reference Number……

Parents Name (or guardian if under 18)……..Parents DOB……

Emergency Contact……Relationship to you……..Phone……

Is this consultation related to a Third Party/Medical Legal Claim? Yes/No

Is this consultation related to a Workers compensation claim? Yes/No

If so please fill in the following details:

Insurance company…… Claim Number……Date of injury……/……/……

Address……State……..Post Code……

Phone……..Fax……...Contact Person……

Employer (at time of injury)……Contact Person……

Solicitor……..Contact Person……

Address……..State……Post Code……..

Phone……..Fax……

PLEASE NOTE:

Your consultation is in the private rooms of a private clinic. Full payment for consultation, plasters, bandages, splints, braces and any other clinical resource is required at the time of consultation unless prior, documented arrangements have been made with this office. An account keeping fee will be charged for any outstanding accounts. A receipt will be issued at time of payment which can be taken to Medicare for a rebate. It is not the policy of this practice to bulk bill for any services rendered. If you are having difficulties paying please discuss with Dr Damiani and the time of consultation.

∗I understand that I will be notified by Damiani Orthopaedics of any clinically relevant pathology results pertaining directly to my surgery.

∗I agree to the above conditions and give my consent for medical information concerning myself or my child to be released to my insurer, employer, solicitor, my referring GP and other health professionals. I give consent to the above information and any other relevant medical information being scanned and stored in my electronic Patient File.

Signed……**Name**……**Date**……/……/……