CONFIDENTIAL

DR BIJOY THOMAS
Orthopaedic Surgeon

PERSONAL DETAILS

Dr Mr Mrs Ms Miss Surname: ___________________________ **First Names:** ____________________________

Address: ____

____ **Postcode:** ________________

Date of Birth: _________________________ **Age:** _____________ **Occupation:** ____________________________

Phone - Home: ___________________ **Work:** ____________________ **Mobile:** ____________________________

Email:____

CONDITION TO BE TREATED: **Left/Right - Hip/Knee – Please circle joint to be treated**

Or other condition: ____

REFERRAL DETAILS:

Referring Doctor: ____ **Referral Date:** ____________________________

Regular Family Doctor (GP): ____

Address: ____

____ **Postcode:** ___________

Do you wish for your regular doctor to be kept informed of your treatment: **YES / NO**

PHYSIOTHERAPIST: ____

MEDICARE/ PRIVATE HEALTH FUND DETAILS:

Medicare No: _ _ _ _ _ _ _ _ _ _ **Valid to:** _ _ / _ _ **Your position on card:** _ _

Private Health Insurance Name: ____

Membership No: ______________________________

Level of cover: TOP (GOLD) / MID (SILVER) / BASIC PLUS (BRONZE) / BASIC / EXTRAS ONLY

Veteran Affairs No: ___________________________ **Gold/White**

WORKERS COMPENSATION/THIRD PARTY DETAILS (IF APPLICABLE)

Employer's Name: ……………………………………………………………………………………………………

Insurance Company Name: ……………………………………………………………………………………………

Claim No: ……………………………………………………… Date of Injury: …………………………………………

Case Manager name & phone: ………………………………………………………………………………………

Solicitor's Details:……………………………………………………………………………………………………

I acknowledge that my medical details may be released to my employer/insurer/solicitor. YES/NO

In some circumstances your Workers Compensation Insurer will not pay the entire amount billed by us for your consultation/operation/procedure. In these circumstances, we will send an account to you or your Employer for the balance of your account.

Ultimately the patient (or his/her guardian) is responsible for the account. In the unlikely event that payment is overdue by more than 90 days and we have tried to recover the payment by sending reminder notices, we may give information about you to a credit reporting agency. This information is limited to your name, sex, address, date of birth, the amount that is overdue and notification that the payment is no longer overdue (when applicable).

I hereby give my consent for medical information concerning myself or my child to be supplied to my referring Doctor/Employer/Insurance Co/Solicitor or any other parties as requested and approved. I also accept that in the event of any dispute, the account rendered becomes the responsibility of the patient (or his/her guardian)

Patient (or Guardian) Signature ____________________________________ **Date** _______________________