CONFIDENTIAL

DR BIJOY THOMAS
Orthopaedic Surgeon

PERSONAL DETAILS – PATIENT 18 YEARS AND UNDER

Master Miss Surname: _____ **First Names**: _____

Address: _____

_____ **Postcode**: _____

Date of Birth: _____ **Age**: _____ **Occupation**: _____

Parent or Guardian Phone _____ **Name:** _____

Email:_____

CONDITION TO BE TREATED: Left/Right - Hip/Knee – Please circle

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:** _ _ / _ _ **Position on card:** _ _

Private Health Insurance Fund: _____

Membership No: _____ **Have you been with fund for over 12 months? YES / NO**

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

PARENT/GUARDIAN:

Dr Mr Mrs Ms Miss Surname: _____ **First Name:** _____

Date of Birth: _____ **Age:** _____ **Occupation:** _____

Your relationship to patient: _____

Same Medicare card as patient? YES / NO **Your position on Medicare card:** _ _

The above information is correct to the best of my knowledge. I hereby give my consent for medical information concerning myself or my child to be supplied to my referring Doctor/Family GP or other parties as requested and approved. I also accept that the account is the responsibility of the patient, parent or guardian.

Patient (or Guardian) Signature _____ **Date** _____

Name: _____