Patient Information

ORTHOPAEDICS WA

Title …….. First Name …… . Surname ……..

Address ……..

Date of birth ……../……../…… . Occupation ……..

Home number …… Work number …… Mobile number ……

Email address ……

Medicare number …… . **Ref** …… . **Exp** ……../…… .

Private health insurance fund …… Number …… .

Aged Pension Only Number …… .

Veteran Affairs Number …… Card Colour ……

Next of Kin …… . Phone ……..

General Practitioner …… .

GP Address ……..

Physiotherapist (if known) Name ……..

Address ……..

CONSENT

I understand that my specialist complies with the Privacy Act (1988). The purpose of collecting my personal information is to provide quality medical and health related services and associated account keeping.

I understand that I have the right to request access to my information (except where access would be denied) and my specialist will make every effort to manage my information in accordance with the National Privacy Policy.

I understand that I may withdraw my consent for my specialist to use my personal information (except where legal obligations must be met). I consent for correspondence to be sent electronically via email.

By typing my name here I give my consent to the above conditions.

Signed …… Date ……

Are you making a claim for a WORK RELATED injury? If **YES**, please complete section below:

Injury ……..

Employer's Full name and Address ……..

……

Insurance company …… . Claim No …… .

Date of Injury ……../……../…… . Case Manager ……

Are you making a claim for a MOTOR VEHICLE related injury covered by ICWA? If **YES**, please complete section below:

Claim No …… Date of Injury ……..

Forms cannot be filled in directly on the website.
Please download this form before filling it in.

SUBMIT FORM