HOLLYWOOD ORTHOPAEDIC GROUP

Dr. Ryan Lisle MBBS(Hons), FRACS(Ortho), FAOrthA
Suite 3, 85 Monash Ave, Nedlands WA 6009
Phone: 08 9 389 3800 Email: lisleadmin@hogwa.com.au

PATIENT DETAILS

First Name: _____ Surname: _____

Date of Birth: _____/_____/_____ Occupation: _____

Mailing Address: _____

Suburb: _____ Postcode: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Email Address: _____

EMERGENCY CONTACT

Next of Kin: _____ Relationship: _____

Home Phone: _____ Mobile: _____

REFERRAL DETAILS

Who has referred you to Mr Lisle: _____

Family Doctor: _____

Medical Group: _____

ACCOUNT DETAILS

Medicare Number: _____ Ref No: _____ Expiry Date: _____
(No. at the front of your name)

Do you have Private Health Insurance: ☐YES ☐NO

Is this Hospital cover: ☐YES ☐NO

If YES: ☐HBF ☐Medibank ☐HIF ☐MBF If other, please state: _____

When did you join your Private Health Fund (Approx): _____

Membership Number: _____

Veterans' Affairs No (if applicable): _____

Have you been hospitalized outside WA in the past 12 months? ☐YES ☐NO

Have you been hospitalized in Royal Perth Hosp since June 2001? ☐YES ☐NO

Have you ever had Hepatitis? ☐YES ☐NO Type: _____

Have you any allergies? ☐YES ☐NO Please List: _____

PLEASE NOTE: AN ADMINISTRATION FEE OF 35% WILL APPLY TO ALL ACCOUNTS NOT PAID WITHIN 60 DAYS

Patients must give their consent (implied, oral or written) for personal information to be collected and used as required by the Privacy Act 1988.

CONSENT

I provide my consent for Mr Ryan Lisle to collect, use and disclose my personal information as required by the Privacy Act 1988 and my consent for him to collect, use and store clinical images for the purposes of my clinical care (including x-rays, intra-operative images and clinical images).
I also provide authorisation for the Practitioner to claim the rebate amount of my consultation direct from Medicare, should my account remain unpaid.

Signature: _____ Witness: _____

FOR WORKERS' COMPENSATION AND MOTOR VEHICLE ACCIDENT PATIENTS, PLEASE COMPLETE OVER PAGE

THIS SIDE ONLY APPLIES TO WORKERS COMPENSATION & MOTOR VEHICLE ACCIDENT CLAIMS

FOR WORKERS COMPENSATION INJURY

Name of Employer: _____

Address: _____

Contact Number: _____

Date of Accident: _____/_____/_____

Employers Insurance Company: _____

Your Claim Number with this Insurance Company: _____

Should this be a new injury and you do not know these details, please check with your Employer and telephone your Surgeon's Rooms with this information as soon as possible. Otherwise the account may be forwarded to you. If your Claim is not accepted by the Insurance Company, you will be liable for any invoices raised in the course of your treatment.

FOR MOTOR VEHICLE ACCIDENT INJURY

Date of Accident/Injury: _____/_____/_____

Claim Number: _____

Did your accident happen in WA? ☐YES ☐NO

AUTHORITY FOR THE RELEASE OF INFORMATION

I _____ (your name) give permission for you to forward confidential information regarding my injury, the treatment I have received and guidelines for return to work to my Employer, Insurance Company and Rehabilitation Provider.

Signature: _____

Date: _____/_____/_____

This signature confirms that I have read the above statement and that I understand and agree with it.