HOLLYWOOD ORTHOPAEDIC | GROUP

Surgeon you are seeing today;

☐ **Dr Nicole Leeks** ☐ **Mr Mike Ledger** ☐ **Mr Clem McCormick** ☐ **Mr Nicholas Frost** ☐ **Mr Aaron Tay**
☐ **Mr Jon Spencer** ☐ **Mr Sean Williams** ☐ **Mr Colin Whitewood** ☐ **Mr Homan Zandi** ☐ **Mr Ryan Lisle**
☐ **Mr Andrej Nikoloski**

► PATIENT DETAILS

Dr / Mr / Master / Mrs / Ms / Miss / Other (Circle one)

First Name: _____ Surname: _____

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

Address: _____

Suburb: _____ Postcode: _____

Phone - Home: _____ Phone – Mobile: _____

Email – Personal: _____

Medicare No.: __ __ __ __ __ __ __ __ __ __ __ **Ref No.:** __ **Expiry:** __ __ / __ __

Do you have Private Health Insurance? ☐ **YES** → **Is this Hospital cover?** ☐ **YES** ☐ **NO**

Name of Fund: _____ Membership No.: _____

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

Dept. of Veterans' Affairs Card No.: _____ ☐ Gold Card ☐ White Card

► EMERGENCY CONTACT/NEXT OF KIN DETAILS

Next of Kin:_____ Relationship: _____

Phone – Home:_____ Phone – Mobile: _____

► PARENT/GUARDIAN INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE;

Full Name: _____ Date of Birth: _____ /_____ /_____

Medicare No.: __ __ __ __ __ __ __ __ __ __ __ **Ref No.:** __ **Expiry:** __ __ / __ __

► REFERRAL DETAILS

Referring Doctor: _____ Suburb: _____

Usual Doctor (GP): _____ Suburb: _____

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

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

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

I provide my consent for Hollywood Orthopaedic Group to collect, use and disclose my personal information as required by the Privacy Act 1988 and my consent for Hollywood Orthopaedic Group to collect, use, transfer and store clinical images for the purposes of my clinical care and education (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: _____ Date: _____

How did you find out about us? GP/Specialist Internet Friend Other: _____

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

HOLLYWOOD ORTHOPAEDIC | GROUP

THIS SIDE <u>ONLY</u> APPLIES TO WORKERS COMPENSATION & MOTOR VEHICLE ACCIDENT CLAIMS

<u>FOR WORKERS COMPENSATION INJURY</u>

Your Employer's Details:

Name of Employer: _____

Address: _____

Contact Number: _____

Date of Accident: _____

Employer's 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.

<u>FOR MOTOR VEHICLE ACCIDENT INJURY</u>

Date of Accident/Injury: _____

Claim Number: _____

Did your accident happen in WA? ☐ YES ☐ NO

<u>AUTHORITY FOR THE RELEASE OF INFORMATION</u>

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.

Please note, if your claim is not accepted by the Insurance Company, you will be liable for any invoices raised during the course of your treatment.