

Patient Information

Patient Details

Surname _____ Title _____
First Name _____ Middle Name _____ Date of Birth _____
Address _____
Telephone: Home _____ Work _____ Mobile _____
Occupation _____ Parent's name if under 18 years old: _____

Treatment Area

please tick

Left Right Both Shoulder Elbow

Referring Doctor

Name _____
Address _____
Phone _____ Date of Referral _____

General Practitioner

These details allow us to keep your family doctor informed of your treatment.

I do not have a family doctor/General Practitioner As above, referring doctor

Name _____
Address _____
Phone _____

Health Insurance

please tick

Private Health Fund Name of Fund: _____
 NO Private Health Insurance (Self-funded)
 Veterans' Affairs No _____

Are you making a claim for compensation? **NO** please tick

Workers' Compensation CTP Personal Injury Claim Public Liability

Claim Number _____ Date of Injury _____
Insurance Company _____
Address _____
Case Manager's Name _____
Telephone _____ Fax Number _____

Declaration

I have read the Privacy Amendment Act provided and give permission for correspondence to be sent to my referring Doctor and General Practitioner and Insurance Company where appropriate.

I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.