coastal orthopaedics

Patient Information

Please complete all pages and sign.

Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Mx ◯ Dr ◯ (Please tick) Surname _____

Given Names _____ DOB _____

Address _____

Suburb _____ Postcode _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Email _____ Occupation _____

Parent/Guardian Full Name (If under 18) _____ DOB _____

Medicare No. | | | | | | | | | | |

Reference No. (Next to Name) | |

Reference No. (Parent/Guardian) | |

Private Health Insurance (Please tick) Yes ◯ No ◯

Fund Name _____ Member No. _____

Pension Card No. _____ Expiry _____

Veterans' Affairs Card No. _____ Colour _____ Expiry _____

Referring Doctor _____ Practice/Suburb _____

Usual GP (If not referring doctor) _____ Practice/Suburb _____

Physiotherapist _____ Practice/Suburb _____

Next of Kin

Name _____ Phone _____

Relationship to Patient _____

Injury Details

Injured body part (right/left) _____

Date of injury _____ Duration of symptoms _____

Current diagnosis _____

Treatment so far _____

Imaging Details

Scan (eg, X-ray, MRI) _____ Provider (eg, PRC, SKG, Envision) _____

Scan (eg, X-ray, MRI) _____ Provider (eg, PRC, SKG, Envision) _____

Scan (eg, X-ray, MRI) _____ Provider (eg, PRC, SKG, Envision) _____

Previous Orthopaedic Surgery

Body part _____

Operation _____

Surgeon _____ Date _____

Coastal Orthopaedic Group Pty Ltd ABN 90 138 792 999
PO Box 58 Claremont WA 6910 **T** 08 9230 6333 **F** 08 9230 6332
E info@coastalorthopaedics.com.au **W** coastalorthopaedics.com.au

Claremont • Murdoch • Mandurah
Waikiki • Lathlain • Carine • Northam
Esperance • Dunsborough • Kalgoorlie

Medical History

Issue _____

_____

_____

Medications _____

_____

_____

Height _____ Weight _____

Smoker (Please tick) Yes ◯ No ◯ How many years _____

Drug allergies _____

COVID-19 vaccination status First dose ◯ Second dose ◯ Third dose ◯

Complete only if workers compensation or motor vehicle accident

Date of injury/accident _____ Type of injury _____

How did the injury occur? _____

_____

Insurance company _____ Claim No. _____

Occupation _____ Employer _____

Phone _____ Address _____

Suburb _____ Postcode _____

Name of solicitor (If any) _____

All patients please sign

I, _____ authorise the release of Clinical information and Reports relating to my condition as treated by Coastal Orthopaedic Group. In the event that my claim is rejected I accept that it is my responsibility for settling all accounts with Coastal Orthopaedic Group.

Signed _____ Date _____

PLEASE COMPLETE THIS FORM PRIOR TO YOUR APPOINTMENT and EMAIL IT BACK TO

info@coastalorthopaedics.com.au

If this is difficult please bring the completed form to your appointment.

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PATIENT PRIVACY CONSENT FORM

Coastal Orthopaedic Group is committed to maintaining the privacy of our patients. In order to safely and effectively provide you with the best care possible, we may collect, use and store personal and health information from you and other health professionals involved in your care.

Coastal Orthopaedics may also need to provide your personal or health information to others (such as specialists or other members of your care team) so you receive quality and effective care.

We may also use personal information as part of our billing and administrative processes, in order to comply with Medicare and Health Insurance Commission Requirements.

A copy of our full Privacy Policy is available on our website. The Privacy Policy contains information about obtaining and updating your personal information, how we deal with your personal and health information and how you may raise any concerns or make a complaint.

Your Acknowledgement

- ◯ I acknowledge and agree to Coastal Orthopaedics collecting, using and storing my personal and health information in accordance with this consent form and Coastal Orthopaedics' Privacy Policy.
- ◯ I agree to Coastal Orthopaedics communicating with me by email. I understand that email communication is not a secure method of communication but that any email communication from Coastal Orthopaedics which contains sensitive information will be flagged confidential.

Patient name_____

Patient signature_____ Date_____

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