NEW PATIENT DETAILS

This form preserves your privacy, as personal details will not be asked in presence of other patients.
Once details are entered into your secure file this document is destroyed immediately.

Surgeon to whom you are being referred to:

Title: Surname:

Given name: Preferred name:

Date of Birth:

Home Phone: Work Phone: Mobile:

Address:

Suburb: Postcode:

Postal Address (If different):

Name of Referring Doctor: Usual GP:

Medicare Care Number: _ _ _ _ _ _ _ _ _ _ _ No. next to your name: _ Expiry:

Do you have Private Health Insurance: Yes No

Name of Fund: Membership No:

Aged Pensioner Card:

Veterans Affair Card Numbers: Gold: White:

Next of Kin: Relationship: Contact no:

Insurance/Compensation Claim: Claim No:

Case Manager:

As a health care provider in the private sector the Reef Orthopaedic Clinic is bound by the National Privacy Principles provided in the Privacy Act 1988. These govern how we collect, handle, use, distribute and store personal information collected from our patients at the clinic. Ordinarily we don't release the contents of your file without consent. However, there may be occasions when the law requires us to disclose certain information without your consent. When dealing with other health care professionals, in order to obtain accurate diagnosis or treatment options we will ask your full consent to disclose personal medical details. Please indicate below and sign your consent for details to be disclosed when necessary.

I Do **Do Not**

(Please circle) give permission for details relating directly to my medical condition be discussed with other health care professionals so that the highest standard of care may be achieved.

Patient Name: **Signature:**