MURDOCH ORTHOPAEDIC CLINIC

BEN JEFFCOTE HIP, KNEE AND ANKLE SURGERY

Patient Information Form

Personal Details:

TITLE:

DATE OF BIRTH:

FIRST NAME:

SURNAME:

RESIDENTIAL ADDRESS:

POSTAL ADDRESS (if different):

HOME PHONE:

MOBILE:

EMAIL ADDRESS:

OCCUPATION:

MEDICARE DETAILS:

NUMBER:

REF:

EXPIRY DATE:

PRIVATE HEALTH INSURANCE DETAILS:

FUND:

MEMBERSHIP NUMBER:

VETERANS AFFAIRS CARD DETAILS:

NUMBER:

TYPE OF CARD:

EMERGENCY CONTACT/NEXT OF KIN DETAILS:

NAME:

RELATIONSHIP:

CONTACT NUMBER:

Provider Details:

REFERRING DOCTOR:

CLINIC:

USUAL/FAMILY DOCTOR:

CLINIC:

PHYSIOTHERAPIST:

CLINIC:

OTHER TREATING SPECIALIST:

CLINIC:

Workers Compensation/Motor Vehicle Accident Claim Details:

IS YOUR APPOINTMENT REGARDING A WORKERS COMPENSATION OR MOTOR VEHICLE ACCIDENT CLAIM?

IF YES, PLEASE COMPLETE BELOW.

EMPLOYER DETAILS:

NAME: PHONE NUMBER:

ADDRESS:

CLAIM DETAILS:

INSURANCE COMPANY: CLAIM NUMBER:

DATE OF INJURY/ACCIDENT: CASE MANAGER NAME:

CASE MANAGER PHONE: CASE MANAGER EMAIL:

Authority to Use/Release of Information:

Our practice will need to collect your personal information to provide healthcare services to you.
We may access or disclose your health information for:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- For research and quality assurance. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the option to opt out of this.
- To comply with any legislative or regulatory requirements e.g. Subpoena
- For reminder notifications which may be sent to you regarding your health care and management.

I,

PATIENT NAME

Consent to my personal information being collected and distributed as outlined above;

Consent to deidentified personal information, including videos and photos being used for the purposes of research and teaching;

Consent to my personal information regarding my injury, treatment and guidelines for return to work being discussed and distributed to my employer, insurance company and rehabilitation provider in regards to a worker's compensation claim, if applicable;

Consent to receiving correspondence digitally via email and SMS.

SIGNATURE DATE:

Medical History:

PLEASE INDICATE IF YOU CURRENTLY SUFFER FROM OR HAVE ISSUES WITH ANY OF THE FOLLOWING. IF YES, PLEASE PROVIDE MORE INFORMATION.

YES	NO	ADDITIONAL COMMENTS
☐	☐	ALLERGIES: _____
☐	☐	ANAESTHETIC: _____
☐	☐	BLOOD THINNERS/ANTI-COAGULATION: _____
☐	☐	BLOOD PRESSURE: _____
☐	☐	CARDIOVASCULAR: _____
☐	☐	MOBILITY DIFFICULTIES: _____
☐	☐	RESPIRATORY: _____

Other Medical History:

PLEASE INDICATE IF YOU HAVE ANY OTHER MEDICAL HISTORY YOU WOULD LIKE NOTED THAT IS NOT LISTED ABOVE (E.G. OTHER CHRONIC HEALTH CONDITIONS, PREVIOUS LOWER LIMB SURGERY).

Medication:

PLEASE LIST YOUR CURRENT MEDICATION:

MEDICATION NAME	DOSAGE	FREQUENCY

How did you hear about Ben Jeffcote?

PLEASE TICK ALL THAT APPLY.

- ☐ GP
- ☐ FRIEND/RELATIVE
- ☐ LAWYER/INSURANCE COMPANY
- ☐ OTHER, PLEASE SPECIFY _____
- ☐ GOOGLE
- ☐ PHYSIOTHERAPIST
- ☐ WORKPLACE REHAB PROVIDER