Patient Information Form

WEST COAST ORTHOPAEDIC CENTRE

SURGEON (Please Tick)

- ☐ Mr Will Blakeney — Ph: 9489 8733 — E: blakeney@wcortho.com.au
- ☐ Mr Nick Kovac — Ph: 9489 8755 — E: Kovac@wcortho.com.au
- ☐ Mr David Colvin — Ph: 9489 8788 — E: colvin@wcortho.com.au
- ☐ Mr David Graham — Ph: 9489 8744 — E: graham@wcortho.com.au

How did you hear about us?

Section A: Personal Details

Title | First Name | Preferred Name | Surname

Residential Address | Suburb | Postcode

Postal Address (if different) | Suburb | Postcode

Date of Birth / / | Home Phone | Work Phone | Mobile Phone

Email Address (Personal) | Occupation

Medicare Card Number (10 digits) | Medicare Reference Number | Medicare Exp Date /

Private Health Fund | Membership Number | Hospital cover included? ☐ Yes ☐ No

Pension / Veterans' Affairs Number (if applicable) | Type of Veterans' Affairs Card | Exp Date / /

Referral Details

Referring doctor | Suburb / Clinic

Family doctor | Suburb / Clinic

Physiotherapist / Other treating professional | Suburb / Clinic

Emergency Contact Details

Next of Kin | Relationship to you | Mobile Phone

Hospital Admission

Have you been an in-patient or worked in a hospital / care facility in the latest twelve months? ☐ Yes ☐ No

Is this appointment regarding a workers' compensation or motor vehicle injury? ☐ Yes ☐ No
If yes, please complete section C or D.

Section B: Consent / transfer of health information

When were your last X-Rays / MRI ? | Where were your last X-Rays / MRI done?

This signature confirms your consent for us to collect this information from you for the primary purpose of providing quality health care. The information will also be used for administrative, billing and debt collection purposes, and for referrals and requests regarding your health care and may be distributed by email to relevant parties.

Signed | Date / /

I consent to anonymous, de-identified information regarding my treatment, including photographs and videos being used for research and teach purposes.

Signed | Date / /

Section C: Workers' Compensation information

Employer Name

Employer Telephone Number

Employer Postal Address

Suburb

Postcode

Employer's Insurance Company

Case Manager Name

Claim Number

Site of Injury

Date of Accident / /

Authority for Release of information

I, 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.
This signature confirms that I have read, understood and agree with the terms of the above statement.

Signed

Date / /

Section D: Motor Vehicle Accident information

Did your accident happen in Western Australia? Yes No If no, in which state did it occur?

Claim Number

Site of Injury

Date of Accident / /

Authority for Release of information

I, 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.
This signature confirms that I have read, understood and agree with the terms of the above statement.

Signed

Date / /

Section E: Account Holder information (if different from patient)

Title

First Name

Surname

Residential Address

Suburb

Postcode

Postal Address (if applicable)

Suburb

Postcode

Date of Birth / /

Home Phone

Work Phone

Mobile Phone

Email Address

Occupation

Medicare Card Number (10 digits)

Medicare Reference Number

Medicare Exp Date /

Private Health Fund

Membership Number

Hospital cover included? Yes No