SURNAME
(MR/MRS/MISS/MS) ……………………………………………………………………………………………………….............

GIVEN NAMES: ……………………………………………………………………………………………..

ADDRESS: ……

SUBURB: ……………………………………………………………………………………… **P/CODE:** …………………………

PHONE NO: (HOME) …………………………….**(WORK)** …………………………**MOBILE:** ……………….......................

EMAIL ADDRESS: ……….
do you want any correspondence sent to you via your email address? Yes ☐ No ☐

DATE OF BIRTH: …………………..................... **OCCUPATION:** ………...…………………………………………………….

NEXT OF KIN: ……….

RELATIONSHIP TO PATIENT: ………………………………………….. **CONTACT NO:** ………………………….................

REFERRING DOCTOR: ……
FAMILY DOCTOR (IF DIFFERENT TO ABOVE): ………………………………………………………………………………

PRIVATE HEALTH FUND: …………………… **PRIVATE HEALTH FUND NO:**……………………………………………….

MEDICARE NO _ _ _ _ _ _ _ _ _ _ **REF** _ (the number to the left hand side of your name)

DEPARTMENT OF VETERANS AFFAIRS NUMBER: ………………………………………………………………………..

LIST ALL CURRENT MEDICATIONS (INCLUDING NON PRESCRIPTION & HERBAL)

…….

………………………...

LIST PREVIOUS MAJOR OPERATIONS, MEDICAL PROBLEMS

…….

…….

DO YOU HAVE ANY ALLERGIES, IF SO PLEASE STATE:

…….

CONSENT: I understand that Murdoch Orthopaedic Clinic and the surgeons within the Group comply with the Privacy Act (1988). The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping. I understand that I have the right to request access to my information (except where access would be denied) and that Murdoch Orthopaedic Clinic/Surgeons make every effort to manage my information in accordance with the National Privacy Policy. I understand that I may withdraw my consent for Murdoch Orthopaedic Clinic/Surgeons to use my personal information (except when legal obligations must be met).

SIGNATURE ………………………………………………………………………… **DATE** …………………………………………

Where did you hear about this clinic?: Newspaper ☐ **Internet** ☐ **General Practitioner** ☐ **Other** ☐