Coastal Orthopaedic Group Pty Ltd
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Claremont WA 6910
PHONE 08 9230 6333
FAX 08 9230 6332
WEBSITE
coastalorthopaedics.com.au

Coastal Orthopaedics

PATIENT INFORMATION

Please complete all pages and sign

Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr ◯ (please tick) Surname _____

Given Names _____ DOB _____

Address _____

Suburb _____ Post Code _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Email _____

Occupation _____

Medicare No. | | | | | | | | | | | Reference No. *(next to name)* | |

Private Health Insurance (please tick) Yes ◯ No ◯

Fund Name _____ Member No. _____

Pension Card Number _____ Expiry _____

Veterans Affairs Card No. _____ Colour _____ Expiry _____

Referring Doctor _____ Practice/Suburb _____

Usual GP _____ Practice/Suburb _____
(if different from referring doctor)

Physiotherapist _____ Practice/Suburb _____

Next of kin details

Name _____ Phone _____

Relationship to patient _____

Injury details

Injured body part (right left) _____

Date of injury _____ Duration of symptons _____

Current diagnosis _____

Treatment so far _____

Imaging details

XRAY (which provider) _____ Date _____

MRI (which provider) _____ Date _____

Ultrasound (which provider) _____ Date _____

CT (which provider) _____ Date _____

Previous Orthopaedic Surgery

Body Part _____

Operation _____

Surgeon _____ Date _____

Medical History

_____

_____

_____

Medications _____

_____

_____

Smoker (please tick) Yes ◯ No ◯ How Many Years _____

Drug allergies _____

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 _____ Post Code _____

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.