Dr. SUPREET BAJWA
DNB, Dip. Orth, MBBS
CONSULTANT ORTHOPAEDIC
HIP & KNEE SPECIALIST

PATIENT INFORMATION FORM

DATE: ____________________

LOCATION:

GENERAL PATIENT INFORMATION

TITLE: (Mr / Mrs / Ms / Mst / Dr)

GIVEN NAME(S): ____

LAST NAME: ____

AGE: ____ **DATE OF BIRTH:** ____

ADDRESS: ____

TELEPHONE (Home): ___________________ **(Work):** _____________________ **(Mobile):** _____________________________

EMAIL ADDRESS: ____

OCCUPATION: ____

WHO REFERRED YOU? ____ ☐ **GP** ☐ **Specialist** ☐ **Friend** ☐ **Other**

USUAL GP DETAILS (If Different from Above): ____

PHYSIOTHERAPIST DETAILS: ____

EMERGENCY CONTACT INFORMATION:

Name: ____

Relationship: ____

Telephone / Mobile: ____

MEDICARE / HEALTH INSURANCE INFORMATION

INSURANCE STATUS: ☐ **PRIVATE** ☐ **PUBLIC**

MEDICARE NUMBER: ______________________________ **NUMBER ON CARD:** ____________ **EXPIRY DATE:** ___________________

PRIVATE HEALTH FUND: ____________________________ **MEMBERSHIP NUMBER:** ______________________________________

You will receive a rebate from medicare to assist in the consultation fees and/or operative fees. This amount depends on the financial arrangements made. Ultimately you (or your guardian) are responsible for the account.

I understand and agree that I am responsible for payment of all charges including those not fully paid for by my insurance company.

FULL NAME: ____

SIGNATURE: ____

DATE: ____