ORTHOPAEDICS WA

Surname _____First Name _____Title _____

Address _____

Date of birth _____ / _____ / _____ Occupation _____

Home number _____ Work number _____

Mobile number _____ Email address _____

Medicare number _____ **Ref** _____ **Exp** _____ / _____

Private health insurance fund _____ Number _____

Aged Pension Only Number _____

Veteran Affairs Number _____

Referring Doctor _____

General Practitioner (if not referring Dr) _____

GP Address _____

CONSENT - I understand that my specialist complies with the Privacy Act (1988). The purpose of 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 my specialist will make every effort to manage my information in accordance with the National Privacy Policy.
I understand that I may withdraw my consent for my specialist to use my personal information (except where legal obligations must be met).

Signature ..... Date .....

Are you making a claim for a WORK RELATED injury?

If **YES** , please complete section below: Injury _____

Employers Full name and Address _____

_____

Insurance company _____ Claim No _____

Date of Injury _____ / _____ / _____

Are you making a claim for a MOTOR VEHICLE related injury covered by ICWA?
If **YES** , please complete section below:

Claim No _____ Date of Injury _____