

ORTHOPAEDICS WA

Title _____ First Name _____ Surname _____

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 _____

Next of Kin: _____ Phone: _____

General Practitioner _____

GP Address _____

Physiotherapist (if known) Name: _____

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). I consent for correspondence to be sent electronically via email.

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 ____ / ____ / ____ Case Manager _____

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 _____