CONFIDENTIAL PATIENT REGISTRATION FORM

Please Circle: Mr / Mrs / Ms / Miss / Master / Dr

Surname: ______________________ Given Names: ________________________

Date of Birth: ___________ Age: ______ Gender: Male / Female

Postal Address: ____________________________________ Postcode: ________

Mobile: ______________ Home Phone: ___________ Work Phone: ___________

E-mail Address: ________________________________

Occupation: _____________________ Employer: __________________________

Next of Kin: _____________________ Contact Number: ______________________

Medicare Card Number: ______________ IRN (Position on Card): ___ Expiry Date: _______

Private Health Fund: HBF / Medibank / ahm / Bupa / nib / Other: ___________

Membership Number: ____________________ Position on Card: ____

DVA Card: Gold / White / Orange Card Number: _______________ Expiry Date: _______

Family Doctor: ___________________ Clinic Name: _________________________

Is this a Workcover/ICWA/Sports Club or other Insurance Claim? Yes / No Claim ID:________________

How did you discover our clinic?

Word of Mouth / Hospital / Driving past / Yellow pages / Internet / Social Media / Other: ____________

Sporting club (please specify): _______________

Signed: _______________________ Date: ___________

Please note

This is a private practice and fees are payable at the time of consultation. Should payment of these fees present a problem, please discuss this with the staff and notify the office prior to your consultation if you require consideration.

There is a $25 cancellation fee for appointments cancelled with less than 24 hours' notice.

*HICAPS and EFTPOS facilities available

9841 7363
scsportsmed.com.au
reception@scsportsmed.com.au
29 Barker Rd, Centennial Park, Albany, 6330

CONSENT STATEMENT

Name: ______________________________________ Date: ______________

Our practice is committed to providing you with quality, continuing care, including the protection of the confidentiality of your records. As part of this care and in compliance with the Private Legislation, it is important that we gain your consent to collect and use personal information about you, only as necessary. Our practice has a Privacy Policy on the collection, use, disclosure and security of information obtained from our patients.

I hereby acknowledge that health information is required to be collected by the clinicians at South Coast Sports medicine to provide me with effective and appropriate health care management.

I consent to and authorise the collection of such information by the practitioners of South Coast Sports Medicine and I agree that my medical records may be retained and utilised by the health professionals at South Coast Sports Medicine for the purpose of future health care treatment and or management

I consent to information regarding my condition, treatment and management being given to and received by doctors, other treatment providers, hospital, pathology, radiological services and or one of the following third-party bodies – Please circle the appropriate third party:

Workcover / ICWA / Insurance Company / or nominate: _________________

I/We understand and agree to be bound by the Consent Statements and the Financial Terms and Conditions set out herein.

Signed (Patient): ____________________________________ Date: ______________

Signed (Parent/Guardian): _____________________________ Date: ______________

CANCELLATION FEE POLICY

I am aware fees are payable at the time of consultation and that there is a $25 cancellation fee if I cancel an appointment with less than 24 hours' notice

Signed (Patient): ____________________________________ Date: ______________

Signed (Parent/Guardian): _____________________________ Date: ______________

Witness: ____ Date: ______________

south coast
sports medicine

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SPORTS MEDICINE QUESTIONNAIRE

Regular Medication (include Aspirin): ____

____

Are you allergic to any of the following:

Medications? (e.g. Codeine, Penicillin): ____

Dressings/Tapes: ________________________ Other: __________________________

Do you have a history of the following? (Please tick)

- ❑ Asthma
- ❑ Rheumatic Fever
- ❑ Heart Condition
- ❑ Kidney or Liver Disease
- ❑ Blood Clots
- ❑ Psychiatric Treatment
- ❑ High Blood Pressure
- ❑ H.I.V / AIDS
- ❑ Hepatitis (A, B or C)
- ❑ Dizziness
- ❑ Bone Disease
- ❑ Epilepsy
- ❑ Neuromuscular Disease
- ❑ Diabetes
- ❑ Stroke/s
- ❑ Arthritis
- ❑ Stomach Ulcers
- ❑ Cancer / Tumour

Details: ____

Current Complaint: _____________________________ Duration: ____________________

Have you had e-rays or scans relating to your current injury? Yes / No Details: ____________________

Past Injuries: ____

Family History: ____

Do you have an artificial hip, knee or prosthetic implant? Yes / No Details: __________________

Are you pregnant? Yes / No / Maybe _______ weeks

What sport/exercise are you currently participating in? _______________________________

Signed: _________________________ Date: ______________