MELBOURNE ORTHOPAEDIC CENTRE

MR JAMES CHIU
MBBS FRACS (orth.)
ORTHOPAEDIC SURGEON

PATIENT REGISTRATION FORM

Personal Details

Title: Mr Mrs Ms Miss Dr Prof (Please Circle)	
First Name:	Middle Name:
Preferred Name:	
Surname:	
DOB: / /	Gender: M / F
Street Address:	
Suburb:	Post Code:
Home Phone:	Mobile:
Email:	
Medicare Number: Reference Number:	Expiry Date: ___/_____
Veterans Affair: Yes / No	DVA Number:
Private Health Fund:	
Health Fund Membership Number:	

UNDER 18 YEARS OF AGE (If applicable)

Parent/Guardian Full Name:	
Parent/Guardian Medicare Number: Reference Number:	
DOB:	Phone:

NEXT OF KIN

First Name:	Surname:
Phone:	Relation:

REFERRING DOCTOR

Name:	Phone:
Address:	

FAMILY DOCTOR

Name:	Phone:
Address:	

PHYSIOTHERAPIST

Name:	Phone:
Address:	

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Appointment Reminder, Messages & Emails

Please advise the front desk staff if you do not wish to receive SMS reminders, or any other message or emails.

- *I consent to receive SMS reminders, messages and emails*. ___***Yes*** ___ ***No***

Privacy Policy

I understand that this practice handles personal information in accordance with the National Privacy Principles enshrined in the Privacy Act 1988 (Commonwealth) and as outlined in the Privacy Statement.

- *I consent to the handling of my information by this practice for the purpose of providing quality health care, administrative billing purposes and communication with other treating allied health professionals e.g. physiotherapist.* ___***Yes*** ___ ***No***
- *I also give permission for medical information to be obtained from any other source in order to help with my treatment.* ___***Yes*** ___ ***No***

Payment Policy

I understand that this practice accepts bank transfer, Visa, MasterCard, and bank cheque only (personal cheque and Amex are NOT accepted). Full payment for the consultation is required at the time of consultation. Outstanding accounts may be referred to a debt collecting service.

- *I consent to the above payment policy.* ___***Yes*** ___ ***No***

Signature: _____ Date____/_____/_____