MR JAMES CHIU
MBBS FRACS (orth.)
ORTHOPAEDIC SURGEON

看诊者登记表 (WORKCOVER 职场伤害/TAC 交通伤害)

Personal Details 个人资料

Title 头衔: Mr Mrs Ms Miss Dr Prof (Please Circle 请圈选)	
First Name 名字:	Middle Name 中间名字:
Preferred Name 希望被称呼的名字:	
Surname 姓:	
DOB 生日: / /	Gender 性别: M 男 / F 女
Street Address 地址:	
Suburb 郊区:	Post Code 邮递区号:
Home Phone 住宅電話:	Mobile 手提电话:
Email 电子邮件地址:	
Medicare Number 全民医疗保险卡号码: Reference Number 参考编码: Expiry Date 截止日期: ___/_____	
Veterans 退伍军人: Yes 是 / No 不是	DVA Number 退伍军人卡号码:
Private Health Fund 健康保险公司名称:	
Health Fund Membership Number 健康保险会员号码:	

UNDER 18 YEARS OF AGE (If applicable) 18 岁以下 (如果情况符合)

Parent/Guardian Full Name 父母/监护人姓名:	
Parent/Guardian Medicare Number 父母/监护人全民医疗保险卡号码: Reference Number 参考编码:	
DOB 生日:	Phone 电话:

NEXT OF KIN 近亲联络人

First Name 名字:	Surname 姓:
Phone 电话:	Relation 关系:

REFERRING DOCTOR 转介医生

Name 姓名:	Phone 电话:
Address 地址:	

FAMILY DOCTOR 家庭医生

Name 姓名:	Phone 电话:
Address 地址:	

PHYSIOTHERAPIST 物理治疗师

Name 姓名:	Phone 电话:
Address 地址:	

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WORKCOVER 职场伤害

Name of Employer 公司名称:	Phone 电话:
Employer Address 地址:	
Insurance Company 保险公司:	
Injury Date 受伤日期:	Claim Number 案件号码:
Claim Manager 案件负责人:	Phone 电话:

TAC 交通伤害

Injury Date 受伤日期:	Claim Number 案件号码:
Claim Manager 案件负责人:	Phone 电话:

门诊预约提醒、留言＆电子邮件

Please advise the front desk staff if you do not wish to receive SMS reminders, or any other message or emails. 如果您不希望收到短信提醒或任何其他留言或电子邮件，请通知前台工作人员。

- *I consent to receive SMS reminders, messages and email. 我同意收到短信提醒、留言或电子邮件。*
  __Yes 同意 __ No 不同意

隐私条约

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. 我理解此诊所是根据1988 年的隐私法(Commonwealth)所规定的国家隐私法则与诊所隐私声明原则来处理私人资讯。

- *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. 我同意此诊所为了以提供优质的医疗保健、费用文书管理和与其他合作治疗的专业医疗人士沟通之目的来处理我的资讯，例如物理治疗师等。* ***__Yes 同意 __ No 不同意***
- *I also give permission for medical information to be obtained from any other source in order to help with my treatment. 我同时也允许此诊所为了协助我的治疗之目的，而从其他出处取得我的医疗纪录。*
  __Yes 同意 __ No 不同意

付款条约

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 initial consultation is required at time of consultation. WorkCover and TAC patients are responsible for paying the full private fee of the initial consultation. A receipt will be issued and provided to you to claim reimbursement from your employer, WorkCover insurer or TAC. Please be aware there may be a small gap between this fee and the amount refunded by the employer, WorkCover insurer or TAC.

Any subsequent appointment(s) will be billed directly to the employer, WorkCover insurer or TAC, provided the claim has been formalised and our practice has been provided with relevant details. 我理解此诊所只接受银行转帐、Visa、MasterCard 与银行支票 (診所是不接受个人支票与 Amex 的)。诊咨询门诊费用需要当天全额支付。职场伤害或交通伤害的病患需要负责支付全额的初诊私人费用，诊所会提供收据发票。看诊者可以依据发票向雇主、公司保险或交通事故委员会申请初诊费用补偿。我们的费用与退款金额在某些情况下也许会有微小差额。初诊之后的看诊费用则会直接向雇主、公司保险或交通事故委员会开帐单申请，其前提是案件号码已经正式确认下来，同时案件资讯也提供给到诊所。

- *I consent to the above payment policy.* ***__Yes 同意 __ No 不同意***

Signature 签名: _____ Date 日期:____/_____/_____