MR JAMES CHIU
MBBS FRACS (orth.)
ORTHOPAEDIC SURGEON

PATIENT REGISTRATION FORM (WORKCOVER/TAC)

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:	

MELBOURNE ORTHOPAEDIC CENTRE

MR JAMES CHIU
MBBS FRACS (orth.)
ORTHOPAEDIC SURGEON

WORKCOVER

Name of Employer:	Phone:
Employer Address:	
Insurance Company:	
Injury Date:	Claim Number:
Claim Manager:	Phone:

TAC

Injury Date:	Claim Number:
Claim Manager:	Phone:

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 email.* ***___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 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.

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

Signature: ____ Date____/_____/_________