

Patient Information

Please complete all pages and sign. Mr Mrs Miss Ms Mx Dr (Please tick) Surname DOB Given Names Address Postcode____ Suburb Home Phone ______ Work Phone _____ Mobile Phone _____ Occupation____ Email Parent/Guardian Full Name (If under 18)______ DOB Medicare No. Reference No. (Next to Name) Reference No. (Parent/Guardian) Private Health Insurance (Please tick) Yes No Fund Name Member No. Expiry ____ Pension Card No. Colour Expiry Veterans' Affairs Card No. Referring Doctor Practice/Suburb Usual GP (If not referring doctor) Practice/Suburb Practice/Suburb_____ Physiotherapist **Next of Kin** Phone Name Relationship to Patient **Injury Details** Injured body part (right/left) Date of injury____ Duration of symptoms_ Current diagnosis Treatment so far **Imaging Details** Provider (eg, PRC, SKG, Envision) Scan (eg, X-ray, MRI) Provider (eg, PRC, SKG, Envision)_____ Scan (eg, X-ray, MRI) Scan (eg, X-ray, MRI) Provider (eg, PRC, SKG, Envision) **Previous Orthopaedic Surgery** Body part Operation Date

Medical History		
Issue		
Medications		
Height	Weight	
Smoker (Please tick) Yes 🔾	No How many years	
Drug allergies		
COVID-19 vaccination status	First dose Second dose Third dose	
Complete only if workers of	ompensation or motor vehicle accident	
	Type of injury	
How did the injury occur?		
Incurance company	Claim No	
Occupation		
Phone		codo
Suburb		code
Name of solicitor (If any)		
All patients please sign		
Ι,	authorise the release of Clinical informa	ition and Reports
	 ated by Coastal Orthopaedic Group. In the event that r	·
	ity for settling all accounts with Coastal Orthopaedic G	
Signed	Date	
oigiled	Date	·

PLEASE COMPLETE THIS FORM PRIOR TO YOUR APPOINTMENT and EMAIL IT BACK TO

info@coastalorthopaedics.com.au

If this is difficult please bring the completed form to your appointment.

PATIENT PRIVACY CONSENT FORM

Coastal Orthopaedic Group is committed to maintaining the privacy of our patients. In order to safely and effectively provide you with the best care possible, we may collect, use and store personal and health information from you and other health professionals involved in your care.

Coastal Orthopaedics may also need to provide your personal or health information to others (such as specialists or other members of your care team) so you receive quality and effective care.

We may also use personal information as part of our billing and administrative processes, in order to comply with Medicare and Health Insurance Commission Requirements.

A copy of our full Privacy Policy is available on our website. The Privacy Policy contains information about obtaining and updating your personal information, how we deal with your personal and health information and how you may raise any concerns or make a complaint.

Your Acknowledgement

C	I acknowledge and a	gree to Coasta	l Orthopaedi	cs collecting	, using and storing	my personal and
	health information in	accordance w	ith this conse	ent form and	Coastal Orthopaed	dics' Privacy Policy.

\bigcirc	I agree to Coastal	Orthopaedics of	communic	ating with me	e by email. I	understand	d that email	
	communication is	not a secure m	ethod of	communicati	on but that	any email c	ommunication	from
	Coastal Orthopaed	dics which cont	ains sensi	itive informati	ion will be f	lagged conf	idential.	

Patient name	
Patient signature	Date