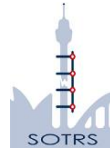


Dr Geoffrey Smith
 Orthopaedic Surgeon
 Shoulder and Elbow Surgery
 MBChB MRCS(Ed) FRACS(Ortho) FAOrthA
 Provider No. 243619YH
 ABN 59 275 536 596



St. George SportsMed
 Orthopaedics and Sports Medicine

CONFIDENTIAL PATIENT REGISTRATION FORM

TITLE: _____ **PATIENT SURNAME:** _____ **GIVEN NAME(S):** _____

ADDRESS: _____ **Post Code:** _____

Date of Birth: ____/____/____ Telephone Hm: _____ Wk: _____ Mobile: _____

Occupation: _____ Email address: _____

Medicare / DVA Number: _____ Expiry: _____ Line Number (Ref): _____

Aged Pension Card No: _____

Health Fund: _____ Membership No: _____

Area of Treatment/Complaint (eg. *Left Elbow*): _____

If patient under 18 years of age please supply Medicare details and DOB for Parent/Payer so we can send claim online to Medicare
 Parent/Guardian's Name: _____
 Parent Medicare Number: _____ Expiry: ____/____ Line Number (Ref): _____ DOB: ____/____/____

Next of Kin Name: _____ Next of Kin Relationship: _____

Next of Kin Telephone No: _____ Contact Next of Kin after Surgery? Yes / No

Usual/Family Doctor/GP: _____ Telephone No: _____

Address: _____

Referring Doctor: _____ Telephone No: _____

Address: _____

Physiotherapist: _____

Address: _____ Telephone No: _____

Practice Privacy Policy

This practice is, as a health provider in the private sector, bound by the National Privacy Principles and the Health Records and Information Privacy Act 2002 (NSW). These Principles set the standards by which personal information is collected from patients. A copy of these Principles is available from the Department of Health or the Australian Medical Association.

As part of your treatment, it is usual to write to your referring Doctor, the Physiotherapist involved in your care, and any other Specialists to whom you are referred, including x-rays MRI's etc.

In the case of compensation matters it may be necessary to write to the Insurers, Solicitor, and Employer and/or rehabilitation provider.

As outlined in the above mentioned guidelines, only the necessary information will be released.

For quality assurance and research, information may be extracted from you record and held on a specific secure database on occasions. It may be necessary for us to contact you for ongoing assessment.

ALL PATIENTS TO SIGN: I HEREBY AUTHORISE THE RELEASE OF MY MEDICAL HISTORY TO MY FAMILY DOCTOR/INSURANCE COMPANY/SOLICITOR WHERE APPLICABLE) AND TO TAKE RESPONSIBILITY FOR THE PAYMENT OF ALL ACCOUNTS PRIVATE OR INSURANCE.

I DO / DO NOT Consent for my de identified Radiographic imaging data and Intraoperative Images to be used for Teaching, Medical Education and Research purposes including computer modelling.

Signed:.....

Printed Name:..... Date:/...../.....

PTO

Dr GEOFFREY SMITH
MBChB MRCS (Ed) FRACS (Orth) FAOrthA
ORTHOPAEDIC SURGEON

All correspondence to:
PO Box 536
KOGARAH NSW 1485

Address for Consultations:
St George SportsMed
Suite 201, Level 2, 131 Princes Highway
KOGARAH NSW 2217

Telephone: 02 9587 4720
Fax: 02 9587 6927

Medical History

	Please tick			Please tick	Other:
High cholesterol	<input type="checkbox"/>	Diabetes	Type 1	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>		Type 2	<input type="checkbox"/>	
Heart Attack / Angina	<input type="checkbox"/>	Cancer		<input type="checkbox"/>	
Cardiac stent	<input type="checkbox"/>	Reflux		<input type="checkbox"/>	
Coronary Bypass Surgery	<input type="checkbox"/>	Liver disease		<input type="checkbox"/>	
Heart valve surgery	<input type="checkbox"/>	Kidney Disease		<input type="checkbox"/>	
Stroke / TIA	<input type="checkbox"/>	Bleeding disorder		<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	DVT		<input type="checkbox"/>	
Lung disease	<input type="checkbox"/>	Pulmonary Embolus		<input type="checkbox"/>	
Previous ECHO scan	<input type="checkbox"/>				

Medication	Dose	Frequency	Medication	Dose	Frequency
Oral contraceptive?					
Hormone replacement?					

Allergies	Please tick	Name	Type of Reaction	Alcohol Please tick	Smoking Please tick	
Antibiotics	<input type="checkbox"/>			<input type="checkbox"/> Yes	<input type="checkbox"/> Never	
Dressings	<input type="checkbox"/>			<input type="checkbox"/> No	<input type="checkbox"/> Prior	When Stopped
Iodine	<input type="checkbox"/>				<input type="checkbox"/> Yes	No. per day
Other	<input type="checkbox"/>					

Other Treating Specialists: eg. Cardiology, Respiratory, Neurologist	Problems with prior anaesthetics	Other Problems with prior surgery

To Be Completed for Workers Compensation or Third Party Claims

CLAIM NUMBER	Insurance Company	Employer	Solicitor
Address:			
Contact Person			
Phone / Fax / Email			
Accident Details Brief Description:			Date of Accident: ____/____/____
Signature: _____ Print Name: _____ Date: ____/____/____			