sportsmed
PREVENTION • TREATMENT • REHAB

Office use only Affix patient identification label in this box

U.R. No.

Temp U.R.

PERSONAL INFORMATION

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐ Male ☐ Female

First name | Middle name | Preferred name/s

Surname | Previous name (if changed since last visit)

Date of birth ␣␣/␣␣/␣␣␣␣ | Marital Status ☐ Single ☐ Married/Defacto ☐ Widowed ☐ Separated ☐ Divorced

Home address (not a PO Box)

Postcode

Mailing address (if different from home address) Postcode

Phone numbers | Home | Work

Mobile | Email

OTHER

Country of birth | Do you require an interpreter? ☐ Yes ☐ No

Occupation

Are you of Aboriginal or Torres Strait origin? (Tick all that apply) ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

HEALTH FUND INFORMATION

Health fund cover (if applicable) | Position on card

Extras ☐ Yes ☐ No Fund name | Membership number

Hospital ☐ Yes ☐ No Fund name | Membership number

Name of contributor (If not the patient) | Date joined

Will a hospital excess apply? ☐ Yes ☐ No (payable on admission) | Amount

Will a co-payment apply? ☐ Yes ☐ No (payable on admission) | Amount

MEDICARE INFORMATION

Medicare card number ␣␣␣␣ ␣␣␣␣␣ ␣ Position on card ␣ | Expiry date ␣␣/␣␣␣␣

if applicable parent name Position on card ␣ | Date of birth ␣␣/␣␣/␣␣␣␣

Reciprocal card (overseas cover) ␣␣␣␣␣␣␣␣␣␣ | Expiry date ␣␣/␣␣␣␣

Safety net number

Veteran's Affairs (DVA) card number | ☐ Gold ☐ White ☐ Orange

If white card, have your hospital costs been approved by DVA? ☐ Yes ☐ No | Expiry date ␣␣/␣␣␣␣

White card accepted conditions

Healthcare card ☐ | Pension card ☐ | Commonwealth Seniors Health card ☐

Card number ␣␣␣␣␣␣␣␣␣␣ | Expiry date ␣␣/␣␣/␣␣␣␣

OFFICE USE ONLY: RESTRICTIONS No ☐ Yes ☐ | **Waits** No ☐ Yes ☐ **Financial** No ☐ Yes ☐

OFFICE USE ONLY ORTHOPAEDIC PATIENTS

Height	Weight	BMI	Date	Notify Surgeon >150kg

REGISTRATION FORM

WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY

Type of claim: Workers Compensation ☐ Third Party ☐ Public Liability ☐

Insurer	Claim number
Cause of injury / body part affected	Date of injury ☐☐/☐☐/☐☐☐☐
Insurer's address (if different to above)	
Suburb	Postcode
Phone	Fax
Name of employer	Contact person / case manager

AUSTRALIAN DEFENCE FORCE PATIENTS ONLY

PM KEYS (EP)

DAN	Body Part	Doctor/surgeon
DAN	Body Part	

REFERRAL SOURCE

How were you referred to sportsmed? (Tick all that apply)

☐ GP ☐ Sports club ☐ Friend/family ☐ Facebook ☐ Instagram ☐ Website ☐ Letterbox flyer

☐ Radio (FIVEaa) ☐ Bus/tram ☐ Billboard ☐ City-Bay Fun-Run ☐ Other .....

NEXT OF KIN

1.	Name		Relationship
	Address (if different to above)		
	Suburb		Postcode
	Phone number home	Mobile	Work

I give consent to disclose relevant information to my next of kin

Patient/nominee signature

EMERGENCY CONTACT

2.	Name		Relationship
	Phone number home	Mobile	Work

GP - MUST BE COMPLETE TO ENSURE CORRESPONDENCE IS SENT BACK TO YOUR USUAL DOCTOR

Full name of usual GP	
Practice/clinic name	
Address	Postcode
Phone number	
Full name of other health practitioner (eg physiotherapy / podiatry)	
Practice/clinic name	
Address	Postcode
Phone number	

DISCLOSURE OF YOUR PERSONAL AND FINANCIAL CONSENT

You acknowledge that where you provide your personal information (including sensitive information, such as health information) to sportsmed, it will be shared across all sportsmed related entities, affiliated health providers or other healthcare professionals as required in undertaking your care, and to ensure continuity of service in providing medical treatment and care to you. If you do not agree to sportsmed sharing your personal information across its related entities, affiliated health providers and other health care professionals, we may be unable to provide services to you or we may be limited in the type or quality of services that we provide to you.

Details on the collection, storage and use of your personal information by sportmed and its related entities is set out in sportsmed's privacy policy available online at: www.sportsmed.com.au/about-us/privacy-statement or in hard copy on request.

You acknowledge that the patient or nominee named herein undertakes to pay the patient payment of the total amount on each attendance or any outstanding balance if your insurer or other payer does not cover the full costs of the consultation/treatment.

Patient/nominee signature Date ☐☐/☐☐/☐☐☐☐