NEW PATIENT REGISTRATION FORM

PATIENT DETAILS:

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss Given Name:_____.

Surname: _____. Preferred Name: _____.

Address: _____.

Suburb:_____. Postcode: _____ .

Date of Birth: _____/_____/_____. Age: _____ Gender: ☐ M ☐ F

Telephone Home: _____. Work: _____. Mobile: _____.

Email Address: _____. Occupation: _____.

Medicare Card Number: _____. Ref # (Next to your name) _____.

Hospital Insurance Fund: _____. Member number: _____.

Veterans Affairs Care Card Number _____. Gold Card: ☐ Yes ☐ No

NEXT OF KIN:

Next of Kin: _____. Relationship: _____.

Contact: _____. Email: _____.

REFERRING DOCTOR:

Full Name: _____.

Clinic Name/Address: _____.
_____.

FAMILY DOCTOR: (if not referring Doctor)

Full Name: _____.

Clinic Name/Address: _____.
_____.

PHYSIOTHERAPIST:

Full Name: _____.

Clinic Name/Address: _____.
_____.

Other Health Professionals (Cardiologist/Myotherapist/Other Surgeons etc.)

Full Name: _____.

Clinic Name/Address: _____.
_____.

Full Name: _____.

Clinic Name/Address: _____.
_____.

MAIN ROOMS AND ALL CORRESPONDENCE:
Ground Floor, 166 Gipps Street
East Melbourne VIC 3002
(03) 9928 6161
(03) 9928 6160
office@phongtran.com.au
phongtran.com.au
Provider No 231799PW
ABN 15 802 551 575
Fellow of the Royal Australasian College of Surgeons
FAORTHA FELLOW of the AUSTRALIAN ORTHOPAEDIC ASSOCIATION

WORKCOVER/TAC Claims:

Date of Injury: _____. Claim Number: _____.

Name of Insurance Company: _____.

Insurance Company Address: _____.

Case Manager: _____. Direct Contact: _____.

Employer's Name: _____. Direct Contact: _____.

Employer's Address: _____.

Where did you hear about us?

- ☐ Referring Doctor
- ☐ Physiotherapist
- ☐ Sports Physician
- ☐ Family Member/Friend
- ☐ Internet
- ☐ Other (please specify): _____.

BILLING AND PRIVACY POLICY

FEES PAYABLE: A referral (within 12 months) from your Local Doctor is required for your Medicare rebate.

INITIAL CONSULTATION	$250
REVIEW	$180

i. I authorize the medical practice to electronically transmit my claim for Medicare benefits to the Australian Government Department for Human Services on my behalf.

ii. I understand 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, associated administrative billing purposes and for other treating allied health professionals. I also give permission for medical information to be obtained from any other source in order to assist with my treatment.

iii. I understand my health information will be used for "secondary purposes" such as auditing, monitoring surgical results and clinical research. Record keeping may also include x-rays and images/photographs. I understand the privacy of individuals is strictly maintained when reporting results of audits or research to the profession. I also consent to information, x-rays and images/photographs being used for the secondary purposes of audit and research.

☐ I have read, understood and consent to the above Billing and Privacy Policy

Print Name: _____.

Signature: _____. Date: _____.