PATIENT REGISTRATION FORM

Dr James McLean

FAMILY SURNAME: ……

GIVEN NAMES: : Dr / Mr / Mrs / Ms / Miss / Mast ……

DATE OF BIRTH: ……EMAIL: ……..

ADDRESS: …… SUBURB: ……..…. POST CODE: ……

TELEPHONE – HOME: ……..… WORK: ……..……..…… MOB: ……..……

MEDICARE CARD NO: ……..…….....REF NO(Next to Name):……..… EXP DATE: ...……

PENSION / CONCESSION / VETERANS AFFAIRS CARD HOLDER YES/NO CARD NO: ....……

PRIVATE HEALTH YES/NO NAME OF FUND: …….. MEMBERSHIP NO: ……..……..……...

Does this cover you for treatment in a private hospital? YES/NO Have you had cover for more than 12 months? YES/NO

FAMILY DOCTOR (GP): ……..…….. .....SUBURB: ……..……

REFERRING DOCTOR: ……..…….. ..SUBURB: ……

HOW DID YOU HEAR ABOUT ORTHOPAEDICS SA? *Please Tick*

□ Dr James McLean's Website	□ OSA website	□ Google / Yahoo / Health Engine / Other
□ GP referral	□ Specialist referral	□ Physio referral
□ Trauma (A&E)	□ Personal recommendation	□ Self referral
□ Repeat Patient	□ Newspaper	□ Other : …….....

NEXT OF KIN: Name: ……..……..……

Relationship to patient: ……..…….. Contact Ph: ……..……

IF PATIENT IS A CHILD (Under 18) Parent/Guardian's Full Name: ……DOB:……

Parent/Guardian's Medicare Number:…….. REF NO(Next to Name):……EXP DATE:…….

IS THIS CLAIM : **A WORKCOVER INJURY YES / NO** OR **THIRD PARTY YES / NO**

CLAIM NO: …….…… INJURY DATE: ……..……

INSURER: ……..……

CASE MANAGER: ……..…….. CONTACT PH: ……..…….....

EMPLOYER: ……..……

EMPLOYER'S ADDRESS: ……..

SOLICITOR: ……..……..

*** THIRD PARTY AND WORKCOVER ACCOUNTS ARE TO BE PAID IN FULL ON THE DAY OF CONSULTATION ***
***BY THE PATIENT IF THE CLAIM HAS NOT BEEN ACCEPTED ***

ACCOUNT INFORMATION

Medicare does not completely cover the cost of your consultation. The consultation fees charged by Dr McLean are as follows:

Initial Consultation:	$ 200.00	**Follow Up Consultation:** **(Includes Public Surgery Post Op)**	$ 110.00
Medicare Rebate:	$ 72.75	**Medicare Rebate:**	$ 36.55
Injections: (No Medicare Rebate)	$ 75.00 - $520.00		

Full payment of your account is required on the day of consultation.

In order to maximise your Medicare Rebate, your referral to Dr McLean needs to be current and valid, otherwise Medicare will pay at a lower rate. Referrals from your GP to Dr McLean only last 12 months from initial consultation. Referrals from another Specialist only last 3 months from your initial consultation. If you do not have a referral or do not bring the referral to the initial appointment you are not permitted to claim a rebate from Medicare or may only be able to claim GP rates. The onus is on you, the patient/parent/guardian, to ensure your referral is kept current. If you require further information please ask our reception staff.

I understand that my care is to be undertaken by Dr McLean as an independent specialist.

Signed…… Date……

PATIENT HISTORY

DR JAMES McLEAN

This information is used to assist Dr McLean in assessing your problem / injury.

AGE…… **HAND DOMINANCE** *(circle)* : LEFT / RIGHT **GENDER** *(circle)* : M / F

NATURE OF EMPLOYMENT……

HOBBIES AND INTERESTS……

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *(Please Tick)*

□ Arthritis	□ Asthma	□ Diabetes	□ Bleeding disorder	□ Clotting disorder
□ Blood pressure (high)		□ Breathing problems / shortness of breath		□ Chest pain / angina
□ Cancer	□ Hepatitis	□ Heart attack	□ Heart condition	□ Kidney disease
□ Lung disease	□ Seizures	□ Steroid therapy	□ Stomach ulcers	□ Stroke / TIAs
□ Thyroid Disease				

ARE THERE ANY OTHER CONDITIONS OR DISEASES NOT LISTED ABOVE THAT YOU HAVE OR HAVE HAD? □ YES □ NO □ NOT SURE

IF YES, PLEASE SPECIFY……

……

DO YOU HAVE ANY CONDITIONS OR THERAPIES THAT COULD EFFECT YOUR IMMUNE SYSTEM? □ YES □ NO □ NOT SURE
(eg leukaemia, HIV, radiotherapy, chemotherapy, steroid therapy)

DO YOU SMOKE? □ YES □ NO □ PREVIOUSLY

DO YOU HAVE ALLERGIES? □ YES □ NO □ NOT SURE

IF YES, PLEASE SPECIFY……

……

PLEASE BRIEFLY DESCRIBE YOUR PROBLEM:

……

……

……

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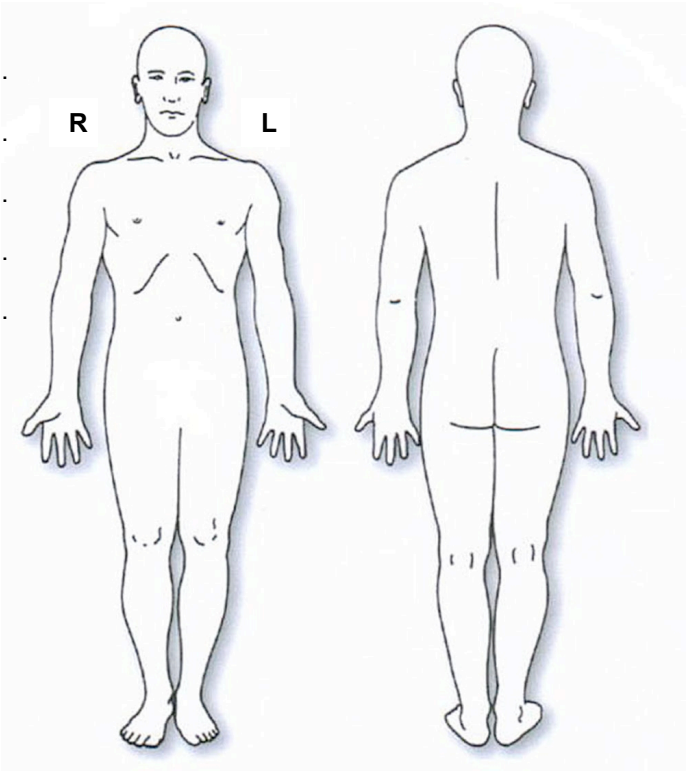
Please indicate on the diagram where you feel pain
(include ALL affected areas)

Mark your worst pain with an X



IF YOUR PROBLEM INVOLVED AN INJURY, PLEASE COMPLETE THE FOLLOWING:

1. Date & Time of Injury:

2. Where the injury occurred:

3. Brief description of the event:

4. Any prior Injury to this site in the past:

5. Names of other practitioners / physiotherapists seen for this injury: