



## Patient Information Sheet for Dr Andrew Morris – Orthopaedic Surgeon

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

D.O.B: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email: \_\_\_\_\_

Residential Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Mobile: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry: \_\_\_\_\_

Private Health Fund: \_\_\_\_\_ Membership No.: \_\_\_\_\_

Pension CRN Number: \_\_\_\_\_ Expiry: \_\_\_\_\_

ADF Personnel: Rank: \_\_\_\_\_ Reg/Unit: \_\_\_\_\_ PM Keys: \_\_\_\_\_

DVA White Card No: \_\_\_\_\_ or Gold Card No: \_\_\_\_\_ Expiry: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer/Company: \_\_\_\_\_

Workers Compensation Claim No. (if applicable): \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Case Manager: \_\_\_\_\_

Usual GP Name & Address: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Mobile: \_\_\_\_\_

Allergies: \_\_\_\_\_

- |    |   |          |
|----|---|----------|
| 1. | Are you allergic to latex?  | YES / NO |
| 2. | Do you have a history of heart disease or high blood pressure?            | YES / NO |
| 3. | Are you a diabetic?   | YES / NO |
| 4. | Do you take Aspirin or blood thinning medication e.g. Warfarin or Plavix? | YES / NO |
| 5. | Do you have a history of malignant hyperthermia?                          | YES / NO |
| 6. | Do you have a history of blood clots?                                     | YES / NO |

### FINANCIAL INFORMATION – Initial Consultation \$200.00 – Review Consultation \$110.00

Deviation to the above fees may occur e.g. Second opinions, medico legal and multiple injuries subject to the Doctors discretion. Other fees apply for Work Cover and Third Party. Other fees may be incurred for management, plaster casts, boots, injections, splints etc.

### CONSENT

I \_\_\_\_\_ (Patient or Legal Guardian's Name)  
have read and understand the above. I agree that payment of the account in full is my responsibility.

I consent to the disclosure to Medical/Specialist Practitioners, Allied Health Practitioners and institutions that may require information about my medical history, but only to the extent necessary to access/treat the particular condition that I have consulted the Specialist Practitioner about. I understand I can retract this consent at any time and to do this must do so in writing. I understand that I will be responsible for and agree to pay all Nautilus Orthopaedics accounts and will indemnify and keep indemnified Nautilus Orthopaedics from all costs, commission, fees, charges and expenses including, but not limited to solicitors costs and debt collection charges incurred by Nautilus Orthopaedics in the recovery of overdue monies.

I have read and understood these terms and conditions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_