Dr. Ben Williams
Orthopaedic Surgeon

Patient Registration Form

Dr / Mr / Mrs / Ms / Miss GIVEN NAME: _____

SURNAME: _____ DATE OF BIRTH: _____

RESIDENTIAL ADDRESS: _____

POSTAL ADDRESS: _____

TELEPHONE - HOME: _____ WORK: _____ MOBILE: _____

EMAIL: _____

MEDICARE NUMBER: ____ ____ ____ ____ - ____ ____ ____ ____ ____ - ____ REF: _____ EXPIRY: _____

PRIVATE HEALTH FUND: _____ MEMBERSHIP NO: _____

VETERAN'S AFFAIRS GOLD CARD NO: _____ WHITE CARD NO: _____

AUSTRALIAN DEFENCE FORCE PERSONNEL RANK: _____ PMKEYS (EP ID): _____

USUAL GP NAME & ADDRESS: _____

OCCUPATION: _____

NEXT OF KIN: _____ MOBILE: _____

ALLERGIES:
_____

IF PATIENT IS A MINOR (Under 18) Parent/Guardian's Full Name:_____

Date of Birth: _____ Medicare Number: ____ ____ ____ ____ - ____ ____ ____ ____ ____ - ____ REF: ____

WORKCOVER OR **MOTOR ACCIDENT CLAIM** DATE OF INJURY: _____

EMPLOYER NAME & ADDRESS: _____

INSURANCE COMPANY: _____ CLAIM NUMBER: _____

CASE MANAGER: _____

PLEASE TICK YES TO ANY OF THE FOLLOWING THAT APPLY. DO YOU HAVE A HISTORY OF:

□ Heart Disease
□ High or Low Blood Pressure
□ Blood Clots
□ Asthma
□ Diabetes
□ Sleep Apnea
□ Malignant Hyperthermia
□ Hepatitis
□ Other _____

FINANCIAL INFORMATION | Dr Ben Williams' fees
Medicare does not completely cover the cost of your consultation. The consultation fee's charged by Dr Williams are as follows and are payable IN FULL on the day of consultation by EFTPOS only. No cash is kept on the premises.
Initial Consultation - $200.00 ($75.05 rebate) **Review Consultation - $110.00 ($37.70 rebate)**
Deviation to the above fees may occur e.g. Second opinions and multiple injuries subject to the Doctors discretion. Other fees may be incurred for plaster casts, boots, injections, splints etc. It is a term of the provision of these services that the patient shall be liable for all debt collection fees and charges if required. I understand that payment of the account in full is my responsibility (not applicable for accepted Workcover claims, Defence Personal, DVA card holders).

CONSENT
I consent to the release and communication of information from or to any other medical provider for the purpose of my ongoing clinical management, ongoing clinical care and audit.

SIGNATURE:_____DATE:_____
(Signature of patient or Guardian if patient is under 16 years of age)