sydney west sportsmedicine

PATIENT REGISTRATION FORM

IMPORTANT: PRIVACY NOTICE

Information collected by us about you will be stored according to the requirements of the Federal Privacy Legislation. It will only be passed on where appropriate in regards to the medical problem you have consulted us for. (eg: your Referrer / GP / Physiotherapist) or where legally required. If you require further information, ask a staff member to see a copy of our Privacy Policy

Mr / Mrs / Ms / Miss / Master / Dr / Other:

Given Name:_____ **Middle Name:**_____ **Family Name:**_____

Preferred Name:_____ **Full Name of Parent in the case of Minors:**_____

Address:_____

Suburb: _____ **Postcode:** _____ **Email:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____ **Occupation:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ __ **Ref no:** ___ **Veterans Affairs Card no:** _____ **Gold / White**

Private Health Insurance? Yes/No **Health Fund Name:** _____ Patient no: _____ **Health Fund Number:** _____

General Practitioner's Name: _____ **Phone:** _____

General Practitioner's Address: _____

Emergency Contact: Name_____ **Relationship**_____ **Phone:** _____

Rooty Hill RSL/SGAC/One55 Membership No: _____ **Expiry:** _____

Complete this section ONLY if this is a WORKERS COMPENSATION or THIRD PARTY claim

Employer (if applicable): _____ **Injured body part** _____ **Date of Injury** _____

Employer's Address: _____ **Phone:** _____

Solicitors Name & Address (if applicable): _____

Insurance Company Name & Address: _____ **Claim Number:** _____

Name of Case Manager: _____ **Case Manager's Phone:**_____ **Case Manager's Fax:**_____

Name of referring doctor for Workers Compensation: _____

Referral Source ***(Please tick appropriate box):***

☐ **Physiotherapist:** **Name:** _____ **Address:** _____

☐ **Coach:** **Name:** _____ **Sport:** _____

☐ **Friend** ☐ **Family** ☐ **Website / Internet** ☐ **Other (Please specify)** _____

PLEASE COMPLETE **SPORTS PARTICIPATION**

Sport and time involved per Week	(School/Club/Social/State/National)	Coach Name and Contact Number
_____	LEVEL _____	_____
_____	_____	_____

ALL PATIENTS PLEASE COMPLETE

The above information is correct to the best of my knowledge. I have ready the Privacy Notice above. I understand that I will be personally responsible for my accounts if any Worker's Compensation / Third Party Claim is not accepted and/or not paid for by Insurance Company.

I agree for my details to be used for research purposes **Yes / No (Please circle)**

I agree to be contactable through any of the means listed above **Yes / No (Please circle)**

PATIENT SIGNATURE: _____ **DATE:** _____

Important: Sydney West Sports Medicine is a multi-disciplinary medical practice and therefore, your medical file will be available to all heath Professionals involved in your treatment and care.