DR MATTHEW WILKINSON

ORTHOPAEDIC SURGEON

ADDRESS: PO BOX 196, HOBART, TAS 7001
TEL: 03 6124 2172
FAX: 03 6251 1527
EMAIL: INFO@DRMATTORTHO.COM.AU
WEB: WWW.DRMATTORTHO.COM.AU
FB: @DRMATTORTHO

Personal Details

Title: _____ Given Names: _____ Surname: _____

D.O.B: ____ /____/ _____ Preferred Name: _____

Occupation: _____

Postal Address:_____

Suburb: _____ State: _____ P/Code: ___ ___ ___ ___

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address_____

Medicare, HealthFund Details

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref no. ____ Expiry: ____ /___
Medicare reference number is the number next to your name on the card

Private Fund Name: _____ Membership No. _____

Have you had **Hospital Cover** for more than 12 months: Yes / No

Next of Kin Contact Details

Name: _____ Contact Number: _____

Relationship to patient: _____ (eg mother, sister, husband)

Department of Veteran Affairs

DVA card number: _____ Card Colour: _____ (eg white or gold)

Specific condition covered: _____

Is your accepted condition related to your appointment today: YES / NO

Defence Force

Please circle: ARMY RAAF NAVY

General Practitioner:_____

Please specify a general practitioner if you would like them to also receive correspondence from your appointment today, your referring doctor will automatically receive correspondence

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Existing Conditions
Diabetic: ○ No ○ Yes, Type 1 ○ Type 2 ○

Cardiac Conditions: ○ No ○ Yes Cardiologists Name: _____

Respiratory Conditions: ○ No ○ Yes, Respiratory Physician: _____

Sleep Apnea: ○ No ○ Yes

Allergies and reactions: _____

Have you previously seen an Orthopaedic Surgeon? Yes ☐ No ☐
Please provide details: (Name) _____ (City/State) _____

Person Responsible for Account
Are you responsible for paying the account today? Yes ☐ No ☐

If you ticked no, can you please specify below who will be responsible for your account.

Full Name: _____

Address: _____

Telephone Number: _____

If you are paying on behalf of the patient and you wish to be the account holder please provide th below information:

Medicare Card Reference No. ____ DOB ____/____/____ Full Name: _____

Consent

I provide my consent for Dr Wilkinson to collect, use and disclose my personal health information as deemed appropriate for the management of the medical condition for which I have sought treatment.

I provide consent for results to be sent to my referring Doctor or General Practitioner by Facsimile/Electronic Mail.
I provide consent for messages regarding myself to be left with immediate family members/defacto partners (eg. Appointment confirmation).

Our Privacy Policy is located at the front desk if you wish to view this.

Print Name: _____ Your Signature: _____
If the patient is under 18 years of age or is unable to give their consent please specify your relationship to the patient and please sign on their behalf.
Relationship to Patient :_____ (eg sister, daughter, mother)

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WORKCOVER/SELF INSURANCE ONLY

Employer's Name (if known) : _____

Where did the injury occur (Town/City): _____

What is the Injury/Disease:

_____

How did the injury occur: _____

_____

Approximate date and time of injury if known: Date / / Time _____ : _____

Claim Number: _____
(If your claim number is pending you will be responsible for the account until we receive your claim number)

Case Manager and number (*if known*) : _____