☐ **Dr Charles Dick** ☐ **Dr Jonathan Dick** ☐ **Dr Kim Latendresse** ☐ **Dr Hans Lombard** ☐ **Dr Dion Noovao** ☐ **Mr James Tunggal**

Patient Information

To assist us with your treatment please complete this form.

SCCO THE SUNSHINE COAST CENTRE FOR ORTHOPAEDICS

Patient Details

Title: _____ First Name: _____ Initial: _____ Surname: _____

Address: Street: _____

Suburb: _____ State: _____ Postcode: _____

DOB: DD / MM / YYYY **Email:** _____@_____ **Occupation:** _____

Phone: Home: _____ Work: _____ Mobile: _____

☐ Check box if you do not wish to receive SMS reminders of your appointments.

Next of Kin: _____ **Relationship:** _____

Phone: Home: _____ Work: _____ Mobile: _____

Referring Doctor

Referring Doctor's Name: _____ **Date of Referral:** _____

Address: _____ **Phone:** _____

Family Doctor's Name (if different from above): _____

Address: _____ **Phone:** _____

Health Insurance

Medicare Card No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **No. Left of Name:** ___ **Expiry:** MM / YY

Do You Have Private Health Insurance: ☐ Yes ☐ No **Name of Health Fund:** _____

Membership No: _____ **No. Next to Name (if Applicable):** ___ **Date Joined:** MM / YYYY

Type of Coverage: Hospital & Extras / Hospital Only / Extras Only **Any Exclusions**: _____

Do You Hold a DVA Card: ☐ Yes ☐ No **DVA No:** _____ **Colour of Card:** _____

Is This A WorkCover Claim: _____ **Date of Injury/Accident:** DD / MM / YYYY **Date of Claim:** DD / MM / YYYY

Claim No: _____ **Case Manager:** _____ (If Known) **Phone:** _____ (If Known)

Insurance Company's Name: _____ **Phone:** _____

Address: _____

Employer's Name: _____ **Phone:** _____

Address: _____

Your Privacy, Our Concern
Consent to Use Your Personal Information

The Sunshine Coast Centre for Orthopaedics complies with the Commonwealth Privacy Act and all other state and territory legislative requirements in relation to the management of personal information. We collect information that is necessary for the provision of your health care. Personal information obtained from you in your consultation may be used to provide information to various health services involved in supporting your health care management (e.g. pathology, radiology, hospitals or other specialists).

I have read and understood The Sunshine Coast Centre for Orthopaedic's Privacy Policy and understand my rights and responsibilities.

I _____ **hereby consent to my personal information being released as and when required.**
(Patient/Guardian/POA)

Signature of Patient/Guardian/POA: _____ **Date:** DD / MM / 20YY

Please continue and complete the health questionnaire.