



**Dr. Simon Elix**  
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:

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Malignant Hyperthermia |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Blood Clots                | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Other _____            |

### FINANCIAL INFORMATION | Dr Simon Elix's fees

Medicare does not completely cover the cost of your consultation. The consultation fee's charged by Dr Elix 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)