Peter Hamilton
ORTHOPAEDIC SURGEON

Mr. Peter Hamilton
M.B.B.S.(Hons) F.R.A.C.S. (Orth) FAOrthA
Orthopaedic Surgeon

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NEW PATIENT FORM

Title: Mr/Mrs/Ms/Miss First Name:_____ Surname: _____

Address: _____

Suburb: _____ Postcode:_____

Phone: Home:_____ Work:_____ Mobile:_____

Date of Birth:_____ Current Age:_____ Occupation:_____

Next of Kin:_____ Relationship:_____ Phone:_____

Person Responsible For Fees: Self / Parent / TAC / WorkCover / Veteran's Affairs / Other

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Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ Exp date:_____ ( ) no. left of name

MIA number:_____

Do you have a Private Health Insurance: Yes / No **Health Fund Name:** _____

Health Fund Membership No:_____ Date Joined:_____

Reason for consultation: Left / Right _____

Referring Doctor:_____

Name & Address of Family Doctor (if different):_____

Do you have an Aged Pension or Health Care Card?: No / Yes Card No: _____ Exp date:_____

Veteran's Affairs Number:_____ Colour of DVA Card:_____

If TAC or WorkCover: Claim No.:_____ Date of Accident / Injury:_____

Insurance Company: _____

Employer:_____

Employer Address:_____

Employer Phone:_____ Contact Person:_____

Medical History

Allergies:_____

Pre-existing medical conditions: (e.g. Cardiovascular disease, Diabetes, Blood clots, Bleeding disorders, Gastric Bypass/Banding surgery, Other)

Yes / No: Details:_____

_____

Regular Medications:_____

_____

Billing: Payment is required on the day of consultation. Outstanding accounts of 30days or more will incur an administrative charge of $30.00. All accounts referred to debt collection service will have all costs added to the amount due

Privacy legislation information: I give consent for Peter Hamilton to collect, hold, use and disclose my personal information (including health information and other sensitive information) for the purpose of my health management. If you would like to see our full privacy policy please contact us directly.

I have read the above, and agree to abide by the payment terms and privacy policy of this practice:

SIGNATURE: _____ **Date:**_____