Mr. Raman Sethi
Orthopaedic Surgeon
MBBS, FRACS (Orth), FAOrthA

Provider No. 573010EJ
03 9999 6795
03 9957 2288
admin@ramansethi.com.au

Patient Registration Form

PERSONAL INFORMATION

Title ____ Given Name ____ Surname ____

Preferred name ____ Date of birth ____ Occupation ____

Mobile ____ Phone ____ Email ____

Address ____ Suburb ____ State ____ Postcode ____

NEXT OF KIN / EMERGENCY CONTACT

Name ____ Relationship ____ Phone ____

Address ____ Suburb ____ State ____ Postcode ____

MEDICARE CARD INFORMATION

Medicare Card No. ____ Ref No. ____ Expiry Date ____

Veteran's Affairs (DVA) Card No. ____ Gold ☐ White ☐ Expiry Date ____

PRIVATE HEALTH FUND (not extras)

Health Fund Name ____ Membership No. ____ Level of Cover ____

Date Joined ____ Name of contributor(if not the patient) ____

Is there copayment/hospital excess on your policy? ☐ Has your health insurance cover changed in the last 12 months? ☐

HEALTHCARE CARDS (if applicable)

Healthcare Card ☐ Pension Card ☐ Card No. ____ Expiry Date ____

WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY

Type of Claim: Workers Compensation ☐ TAC ☐ Third party ☐ Claim No. ____

Name of Insurer ____ Cause of injury ____ Date of injury ____

Case Manager ____ Phone ____ Email ____

GP / REFERRING DOCTOR (must be complete to ensure correspondence is sent back to your usual doctor)

Full name of usual GP ____ Practice/Clinic Name ____

Address ____ Suburb ____ State ____ Postcode ____

Full name of referring Doctor (if different from above) ____ Practice/Clinic Name ____

Address ____ Suburb ____ State ____ Postcode ____

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DETAILS OF YOUR REGULAR PHYSIOTHERAPIST

Full name ☐ Practice/Clinic Name ☐

Address ☐ Suburb ☐ State ☐ Postcode ☐

HEALTH QUESTIONNAIRE (tick if applicable)

Do you have any allergies or sensitivities to medicines, tapes, food, latex or other? ☐ Details if any: ☐

Do you or have you ever smoked? ☐ Do you drink alcohol? ☐

Do you have any of the following:

Diabetes? ☐ Duration of DM ☐ Are you on diet control? ☐ Medication ☐ Insulin ☐

Previous History/ Family history of blood clots? ☐ Details if any: ☐

Any respiratory problems? ☐ COPD ☐ Asthma ☐ Sleep Apnoea ☐ Others ☐

Any heart problems? ☐ MI ☐ Angina ☐ Pacemaker ☐ Heart Surgery ☐

Are you taking blood thinners? ☐ Warfarin ☐ Plavix ☐ Aspirin ☐ Others ☐

List your medications ☐

Any other past history ☐

Any prior surgery ☐

Any H/O infection after surgery ☐

Office Use

Height ____________ Weight____________ BMI ____________

DISCLOSURE OF YOUR PERSONAL INFORMATION

You acknowledge that where you provide your personal information (including sensitive information, such as health information) to us, it will be shared across by us and, affiliated health providers or other healthcare professionals as required in undertaking your care, and to ensure continuity of service in providing medical treatment and care to you. If you do not agree to us sharing your personal information across its related entities, affiliated health providers and other health professionals, we may be unable to provide services to you or we may be limited in the type or quality of services that we provide to you. Details on the collection, storage and use of your personal information by us and its related entities is set out in our privacy policy available online at: www.ramansethi.com.au

FINANCIAL CONSENT

You acknowledge that the patient or nominee named herein undertakes to pay the patient payment of the total amount on each attendance or any outstanding balance if your insurer or other payer does not cover the full costs of the consultation/treatment.

Patient/Nominee______________________________ Signature. ______________________________ Date__________________