PATIENT REGISTRATION & CONSENT FORM

PLEASE COMPLETE, SIGN AND BRING TO YOUR APPOINTMENT

MR. ASH MOAVENI
BHB, MBChB, FRACS, FAOrthA, MPH
Orthopaedic Surgeon
SHOULDER, ELBOW AND WRIST SPECIALIST

PERSONAL DETAILS (please circle) Mr Mrs Ms Miss Other: _____

First Name: _____ Surname: _____Marital Status: _____

Address: _____Post code: _____

Date of Birth: ____/_____/_____ Email: _____ Occupation: _____

Phone: (Mobile) _____(Home) _____(Work) _____

To minimise missing an appointment we send SMS confirmation reminders for all appointments. Please notify main office on 9416 1466 to opt out.

EMERGENCY CONTACT

Name: _____ (Relationship) _____

Contact Number: _____ Permission to disclose medical information to this person? Yes No

USUAL GP

Name: _____

Address: _____

Phone: _____

USUAL PHYSIOTHERAPIST

Name: _____

Address: _____

Phone: _____

HEALTH COVER DETAILS:

Private ☐ Uninsured ☐ DVA ☐ Work Cover ☐ TAC ☐ Overseas Citizen ☐

Medicare No. _____ Ref No.: _____ (Number next to your name on card)

Private Insurance Name: _____Member No. _____

Veteran Affairs No: _____ Gold ☐ White ☐

WORK COVER DETAILS

Insurer: _____ Claim No.: _____

Date of injury: _____ Injury: _____

TAC DETAILS

Claim No.: _____

Accident date: _____

I HAVE READ AND AGREE TO THE BELOW POLICIES AND DISCLOSURE STATEMENT:

SIGNATURE: _____ **DATE: _____/_____/_____**

*__All Work Cover/TAC patients__ are required pay their account on the day of consultation and claim back from applicable party. If surgery is required and approved then the practice will send the account to the insurer/agency directly.

FEE POLICY: Initial consultation: $170 - Review consultation: $90. PAYMENT ON THE DAY OF CONSULTATION.

CANCELLATION POLICY: At least 24-48 hrs. Less than 24 hrs may incur a $90 cancellation fee.

PATIENT IMAGES POLICY: It is the patient responsibility to bring all appropriate imaging (films/reports) to appointments.

DISCLOSURE STATEMENT

- I give permission for my medical details and results to be given to my referring doctor, other doctors and health professionals, including admitting hospital and other third parties ie Work Cover/TAC involved with my care.
- I understand that clinical information may be gathered for ongoing medical research.
- I authorise Mr Moaveni to claim my accounts with a third party when necessary (Medicare, WorkCover, TAC, Private Fund).