

Patient Details

Title

Surname:

Given Name:

Sex: Male / Female

Date of Birth:

/ /

Postal Address:

Residential Address: (If different)

Home Phone No:

Work Phone No:

Mobile Phone No:

(Agree to SMS appointment reminders being sent)

Email Address:

If under the age of 18, parent's name:

Emergency Contact Name:

Phone:

Medical Information

Regular GP:

Regular Physio:

Regular Podiatrist:

Referred by:

GP Physio Podiatrist Other Emergency Department

Medicare No:

Valid to:

Ref No: (eg. 1)

Do you have private health insurance?

Fund Name:

Member No:

Medications: (Please List)

Allergies: (Please List)

Workers Compensation / Third Party / ADF / DVA: (If applicable)

Insurance Company:

Claim No:

ADF/Veterans Affairs:

DAN:

PM Keys:

Imaging

Please tick which of these you have had:

X-Ray MRI Other

Location of imaging

Do you have a link to the images yourself?

Thank you. Our staff will be in contact soon with your appointment date and time.

Authority - Please Read

I agree for Dr Pankaj Rao to be my treating specialist and give permission to be examined with regard to the condition for which I have been referred. I hereby give my consent for medical information concerning myself or my child to be supplied to my referring Doctor / Employer / Insurance Company / Solicitor or any other parties as requested. I also accept that in the event of any dispute then the account rendered becomes the responsibility of the patient or parent / guardian if the patient is under 18 years of age. I certify that the information provided on this form, to the best of my knowledge, to be true and correct.

Signature of Patient / Parent / Guardian

Date

Form Notice

To submit the completed Private Fracture Clinic Form save this file to your device and attach the completed document to an email and send to: Foot@rao.net.au.