DR CALVIN CHIEN
ORTHOPAEDIC SURGEON

NEW PATIENT REGISTRATION FORM

_____ _____ _____
(Salutation*) (Surname*) (First Name*)

Address*: _____

Date of Birth*:_____/_____/_____ Email: _____

Home Phone:_____ Work Phone: _____ Mobile: _____
(at least one contact number required)

Occupation:_____ Language Spoken: _____

Referring Doctor*: _____
(Name) (Address)

Family Doctor*: _____
(as above if the same) (Name) (Address)

Next of Kin: _____
(Name) (Relationship) (Telephone)

Do you have private health cover? ☐ No ☐ Yes, Fund: _____

Fund Membership Number: _____ Cover: _____

Are you an aged pensioner? ☐ No ☐ Yes, Number: _____

Medicare Number*: _____ Patient Ref No: ____ Expiry Date: _____/_____

I authorise release of my records to my referring and/or family doctor* _____
(Sign and Date)

1. Is this Workers Compensation? ☐ No ☐ Yes
2. Is this Third Party/Public Liability? ☐ No ☐ Yes

If you answered <u>YES</u> to any of the 2 questions above, please provide the following details and sign the consent to release records:

Employer: _____ Date of injury: _____
(for Workcover*)
Address:_____ Phone: _____

Insurance Company*: _____ Claim Number*: _____

Solicitor: _____ Contact: _____
(Name) (Number)

Describe Accident and Injury:

_____

_____

_____

_____

I authorise release of my records to my insurance company, solicitor and/or employer*

_____
(Sign and Date)

*Required fields