Orthoclinic
Orthopaedic Clinic Sydney

NEW PATIENT REGISTRATION
Please complete all relevant fields

Title: (Dr Mr Mrs Ms Miss Master) Other: _____

First Names: _____ Surname: _____

Date of Birth: _____ Email: _____

Address: _____ Suburb: _____ Postcode: _____

Postal Address: _____ Suburb: _____ Postcode: _____
(If different)

Phone (H): _____ (W): _____ (M): _____

Next of Kin: _____ Relationship: _____ Phone:_____

We automatically send out an SMS reminder for future appointments. If you do not want to receive a SMS reminder, please tick this box ☐

Occupation: _____ Person Responsible for Fees: _____

Medicare/Veteran Affairs No: _____ Ref: ____ Exp: _____ / _____

Aged Pension No: _____ Exp: _____ / _____

Private Health Fund: _____ Member No: _____

Referring Doctor: _____

Doctors Address: _____

Family Doctor: _____ Phone: _____

Doctors Address: _____

Physiotherapist: _____ Phone: _____

Physios Address: _____

Has another Orthopaedic opinion been sought? _____

How did you hear about Dr Jonathan Herald? _____

Permission to Collect and Store Information and Account Information

I confirm that I understand and carefully answered all the above questions and agree to the collection and storage of information. I authorise Dr Herald to release medical information to the Referring Doctor / Insurance Company / Solicitor or any other persons nominated by me. I allow my medical information to be used for research purposes. Settlement of your account on day of consultation is required. Any overdue consultation/surgical account of 30 days will be given to a collection agency (with your contact and account details) and will attract a 20% service fee of the outstanding amount plus GST.

Signed: _____ Date: _____

If this consultation is to be paid through Workers Compensation, Third Party or Medicolegal, you must complete **Workers Compensation** / **Third Party form** or fees are payable on the day. Thank you.

Orthoclinic – Orthopaedic Clinic Sydney • Suite 118, Level 1, 4 Hyde Parade, Campbelltown NSW 2560
Telephone: 02 9233 3946 • Fax: 02 9009 0663

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GENERAL ASSESSMENT SHEET

Please list and date any previous operations or hospitalisations you have had:

_____

_____

_____

Please list and date any previous or current medical problems:

_____

_____

_____

List your current medications and dosages:

_____

_____

_____

List any allergies:

_____

_____

If you smoke, how much do you smoke per day and how long have you been smoking for?

_____

If you drink alcohol, how much do you drink per day?

_____

- Are you on the oral contraception pill? Yes No
- Have you ever had a blood clot? Yes No
- Did you have any complications from anesthesia? Yes No
- Do you have diabetes? Yes No
- Do you have any infectious diseases? Yes No