sportsmed

Affix patient identification label in this box

U.R. No.

Temp U.R.

Registration Form

PERSONAL INFORMATION

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other | ☐ Male ☐ Female

Surname | Date of birth ☐☐/☐☐/☐☐

Given Names | Preferred Name/s

Marital Status ☐ Single ☐ Married/Defacto ☐ Widowed ☐ Separated ☐ Divorced

Previous Name (if changed since last visit)

Home Address (not a PO Box)

Postcode

Mailing Address (if different from home address)

Postcode

Phone number Home | Mobile

Work | Adelaide Contact

Country of birth | Occupation

Are you of Aboriginal or Torres Strait Origin? (Tick all that apply) ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

Email

MEDICARE CARD INFORMATION

Medicare card number ☐☐☐☐☐☐☐☐☐☐ Ref number ☐ | Expiry Date ☐☐/☐☐☐☐

Reciprocal card (overseas cover) ☐☐☐☐☐☐☐☐☐☐ | Expiry Date ☐☐/☐☐☐☐

Safety net number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Veteran's Affairs (DVA) card number | ☐ Gold ☐ White ☐ Orange

If white card, have your hospital costs been approved by DVA?: ☐ Yes ☐ No | Expiry Date ☐☐/☐☐☐☐

PRIVATE HEALTH FUND (NOT EXTRAS)

Health Fund Name | Level of cover

Membership number Ref number ☐ | Date joined

Name of contributor (If not the patient)

Will a hospital excess apply? ☐ Yes ☐ No | Amount

Will a co-payment apply? ☐ Yes ☐ No | Amount

Has your health insurance cover changed in the last 12 months ☐ Yes ☐ No | If Yes, it is important that you contact your health insurer to clarify your coverage for admission.

HEALTHCARE CARDS (PLEASE TICK)

Healthcare Card ☐ | Pension Card ☐ | Commonwealth Seniors Health Card ☐

Card number ☐☐☐☐☐☐☐☐☐☐ | Expiry Date ☐☐/☐☐☐☐

WORKERS COMPENSATION / THIRD PARTY / PUBLIC LIABILITY

Type of Claim: Workers Compensation ☐ Third Party ☐ Public Liability ☐

Name of Insurer	Claim number
Cause of injury / body part affected	Date of injury ☐☐/☐☐/☐☐

Insurer's Address

Postcode

Phone	Fax
Name of employer	WCA Contact person / Case Manager

AUSTRALIAN DEFENCE FORCE PATIENTS ONLY

EP

DAN	Body Part	Doctor/Surgeon
DAN	Body Part	

NEXT OF KIN / EMERGENCY CONTACT

1.	Name		Relationship
	Address (if different to above)		
	Suburb		Postcode
	Phone number Home	Mobile	Work
2.	Name		Relationship
	Address (if different to above)		
	Suburb		Postcode
	Phone number Home	Mobile	Work

GP / REFERRING DOCTOR - MUST BE COMPLETE TO ENSURE CORRESPONDENCE IS SENT BACK TO YOUR USUAL DOCTOR

Full name of usual GP

Practice/Clinic Name

GP phone number

GP Address

Postcode

Full name of referring Doctor (if different from above):

Practice/Clinic Name

Referrer phone number

Referrer Address

Postcode

DISCLOSURE OF YOUR PERSONAL INFORMATION

You acknowledge that where you provide your personal information (including sensitive information, such as health information) to a sportsmed clinic, it will be shared across all sportsmed related entities, 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 sportsmed 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 sportmed's and its related entities is set out in sportsmed's privacy policy available online at: www.sportsmed.com.au/about-us/privacy-statement or in hard copy on request.

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 ☐☐/☐☐/☐☐