Dr. Brett Fritsch **Orthopaedic Surgeon**

Mr / Mrs / Ms / Miss / Mstr / Dr **Patient information Sheet**

Given Name/s: _____ Preferred name: _____

SURNAME: _____ DOB: ____/____/____

Address: _____

Home:_____ Work:_____ Mobile:_____

Email address: _____

Occupation: _____

Are you required to perform any physical labour at work? YES NO

Please describe: _____

_____

_____

Emergency Contact: _____ Relationship:_____ Phone:_____

Medicare no: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref no:_____ Exp date __ __ / __ __ __ __

Health Fund: _____ M'Ship no: _____

Blue Pension Card no: _____ Expires: __ __ / __ __ / __ __ __ __

Veteran's Affairs (DVA) no: _____ Gold or White (pls circle)

Your Family Doctor: _____ Phone: _____

Your Family Doctors Address: _____

Other Medical conditions: _____

Medications: _____

Allergies: _____

****

Physiotherapist's Name: _____ Tel: _____

Address: _____

_____

****

I have read the PRIVACY ACT CONSENT information regarding the handling of my information by this Practice for the purposes set out in that form. I consent to the handling of that information subject to any limitations on access or disclosure about which I notify this Practice.

Signed: _____ Date: _____

Patient Name: _____ Guardian/Parent: _____

****

WORKERS' COMPENSATION/THIRD PARTY (if applicable) **INJURY DATE:** _____

Employer's Name: _____ Contact Person: _____

Address: _____ Tel: _____

Insurance Co: _____ Contact Person: _____

Address: _____ Tel: _____ **Claim no:** _____

_____