sydney sportsmed specialists

PLEASE COMPLETE **PATIENT REGISTRATION FORM**

IMPORTANT – PRIVACY NOTICE

Information collected by us about you will be stored according to the requirements of Federal Privacy legislation. It will only be passed on where appropriate to the care of the medical problem about which you consulted us (e.g. to your physio or local doctor), or where legally required. If you require more information, ask a staff member to see a copy of our Privacy Policy.

Mr Mrs Master Ms Miss Dr (please circle) **NSW INSTITUTE ATHLETE YES NO (Please circle)**

SURNAME:______________________________

GIVEN NAMES:______________________________**DATE OF BIRTH:**____/____/____ **AGE:**__________

ADDRESS:______________________________

______________________________**POSTCODE:**__________

POSTAL ADDRESS (if different from above):______________________________

______________________________**POSTCODE:**__________**EMAIL:**______________________________

TELEPHONE (H) ( )__________________ **(W) ( )**__________________**(M)**__________________

PATIENT OCCUPATION:__________________ **MEDICARE NO:**__________________ **REF NO: ( ) EXP:**__________________

REFERRAL SOURCE:______________________________**REFERRAL DATE:**____/____/__________

GP:______________________________**GP ADDRESS:**______________________________

COMPLETE ONLY IF APPLICABLE

WORKERS COMPENSATION CLAIM/THIRD PARTY CLAIM (PLEASE CIRCLE)

NAME OF EMPLOYER:______________________________

ADDRESS OF EMPLOYER:______________________________

______________________________POSTCODE:________ PHONE:( )__________________

INSURANCE COMPANY: ______________________________

ADDRESS OF INSURANCE COMPANY:______________________________

______________________________POSTCODE:________PHONE:( )______________

CASE MANAGER:__________________CLAIM NO:__________________DATE OF INJURY:____________

SOLICITOR:______________________________ADDRESS:______________________________

______________________________POSTCODE:________PHONE:( )______________

PLEASE COMPLETE

The above information is correct to the best of my knowledge. I have read the privacy notice above. I understand that I will be personally responsible for my accounts if any compensation claim is not accepted and/or not paid by an insurance company.
I agree for my details to be used anonymously for research purposes YES_____ NO ______ (please circle)
I agree to be contactable through any of the means listed above YES_______ NO ________ (please circle)

PATIENT SIGNATURE______________________________**DATE**_______/_______/__________________

PLEASE COMPLETE **SPORTS PARTICIPATION**

SPORT AND TIME INVOLVED PER WEEK	LEVEL (SCHOOL/CLUB/STATE/NATIONAL)	COACH NAME & PHONE NUMBER
1 ______________________	______________________	______________________
2 ______________________	______________________	______________________
3 ______________________	______________________	______________________

TO BE COMPLETED BY TREATING PRACTIONER ONLY

PAST MEDICAL HISTORY:____

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PAST SURGICAL HISTORY:____

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FAMILY MEDICAL HISTORY:____

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CURRENT MEDICATIONS/SUPPLEMENTS:____

____

ALLERGIES:____

PRESENTING PROBLEM: ____________________ **ONSET:** ____________________ **DURATION:** ____________________

HISTORY OF PRESENTING ILLNESS: **TODAYS DATE:**_______/________/_________________ **DOB:**_____/______/_________

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PREVIOUS TESTS:____

ON EXAMINATION:____

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DIAGNOSIS:____

TREATMENT/PROGRESS:____

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