Melbourne Bone & Joint clinic

MR ARVIND JAIN
MBBS MS FRACS FAOrthA
Orthopaedic Surgeon
Hip, Knee & Shoulder Specialist
Provider No. 276911FB

PATIENT REGISTRATION FORM

PERSONAL DETAILS:

Title: Mr First If other please specify: _____
Name: _____ Preferred Name: _____
Surname: _____ DOB: _____
Street Address: _____ Suburb: _____
Postcode: _____ State: VIC
Postal Address (if different from street address): _____
Home Ph: _____ Work Ph: _____ Mobile Ph: _____
Email Address: _____
Medicare Card No: _____ Number beside name on card: ____ Expiry Date: _____
Private Health Insurance: YES ○ NO ○ If yes, Level of cover: Hospital Only
Private Health Insurance Name: Membership No:
Are you aware of any exclusions in your health insurance policy? YES ○ NO ○
If yes, what are the exclusions? _____

ACCOUNT DETAILS:

Who is responsible for your account today? Self if other please specify: _____ *(if you selected 'self' please proceed to NEXT OF KIN details)*

For Veterans Affairs (DVA) claims complete the following:
Card Colour: GOLD ○ WHITE ○ Card Number: _____

For TAC Claims complete the following:
Date of Accident: _____ Claim Number: _____

For Workcover Claims complete the following:
Date of Injury: _____ Claim Number: _____
Insurance Company: _____
Case Manager: _____ Ph No: _____ Fax No: _____
Employer Name and Address: _____

NEXT OF KIN DETAILS:

Name of next of kin: _____ Relationship: Parent If other please specify: _____
Contact Phone Number: _____

REFERRING DOCTOR INFORMATION:

If your referring doctor your regular GP? YES ○ NO ○
If NO, who is your regular GP?

Doctors Name: _____ Clinic Phone Number: _____
Clinic Name and Address:

Do you have a usual physiotherapist or other allied health care provider? YES ○ NO ○
Name: _____
Clinic Phone Number: _____
Clinic Address: _____

MEDICAL HISTORY

Are you a smoker? YES ○ NO ○
Do you have any allergies? YES ○ NO ○
If yes, what are your allergies? _____

Have you ever had, or do you have any of the following?

Asthma?	YES ○	NO ○	Bleeding Tendency?	YES ○	NO ○
Heart Problems?	YES ○	NO ○	Rheumatic Fever?	YES ○	NO ○
Pacemaker?	YES ○	NO ○	Epilepsy?	YES ○	NO ○
Kidney Disease?	YES ○	NO ○	Hepatitis?	YES ○	NO ○
Diabetes?	YES ○	NO ○	High Blood Pressure?	YES ○	NO ○
DVT/PE?	YES ○	NO ○			

Please list your current medications (please attach own list if space not sufficient):

- _____ _____
- _____ _____
- _____ _____
- _____ _____

Thank you for taking the time to complete our registration form. Please return via email to: admin@boneandjointclinic.com.au