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

SURNAME_____

GIVEN NAMES_____**Date of Birth**_____/_____/_____ **AGE**_____

ADDRESS_____

_____**POSTCODE**_____

EMAIL _____ **Postal Address (if different from above)**_____

_____**POSTCODE**_____

MEDICARE NO_____ **(Ref No) (** _____ **) EXP:**_____

Telephone (H) ( )_____**(W) ( )**_____**(Mob)**_____

REFERRAL SOURCE_____ **PATIENT OCCUPATION**_____

GP_____**GP ADDRESS:**_____

COMPLETE ONLY IF APPLICABLE – **OTHERWISE PLEASE SIGN BELOW**
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( )_____

SIGNATURE - 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 my health information can be sent to me (if requested) or other practitioners involved in my care by fax, email, or mail [cross out any that do not apply].

PATIENT SIGNATURE_____**DATE**_____/_____/_____

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_____

PAST SURGICAL HISTORY_____

_____

FAMILY MEDICAL HISTORY_____

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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