

## PATIENT REGISTRATION SHEET

### 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 Miss Master Ms Dr (Please circle)

**NSW INSTITUTE ATHLETE:** YES NO (Please circle)

SURNAME \_\_\_\_\_ GIVEN NAME(S) \_\_\_\_\_ PREFERRED \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

SUBURB \_\_\_\_\_ STATE \_\_\_\_\_ POSTCODE \_\_\_\_\_

TELEPHONE (H) ( ) \_\_\_\_\_ (W) ( ) \_\_\_\_\_ (Mob) \_\_\_\_\_

MEDICARE NO \_\_\_\_\_ REF No \_\_\_\_\_ EXP. DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ OCCUPATION: \_\_\_\_\_

### **REFERRAL SOURCE** (Please tick appropriate box)

DOCTOR - Name \_\_\_\_\_ Address \_\_\_\_\_ REFERRAL DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PHYSIOTHERAPIST - Name \_\_\_\_\_ Address \_\_\_\_\_

COACH - Name \_\_\_\_\_ Sport \_\_\_\_\_

### **How did you hear about SSMC?**

PRACTITIONER REFERRAL       FRIEND       FAMILY       WEBSITE / INTERNET

OTHER (Please specify) \_\_\_\_\_

### **COMPLETE ONLY IF APPLICABLE**

### **WORKERS COMPENSATION CLAIM / THIRD PARTY CLAIM** (Please circle)

NAME OF EMPLOYER \_\_\_\_\_ TELEPHONE ( ) \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ POSTCODE \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_ TELEPHONE ( ) \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY \_\_\_\_\_ POSTCODE \_\_\_\_\_

CASE MANAGER \_\_\_\_\_ CLAIM NUMBER \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

NAME OF SOLICITOR \_\_\_\_\_ TELEPHONE ( ) \_\_\_\_\_

ADDRESS OF SOLICITOR \_\_\_\_\_ POSTCODE \_\_\_\_\_

PLACE OF MOTOR VEHICLE ACCIDENT \_\_\_\_\_

### **ALL PATIENTS 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**

### **SPORT PARTICIPATION**

SPORT & TIME INVOLVED PER WEEK

LEVEL  
(School/Club/Social/State/National)

COACH NAME & TELEPHONE NUMBER

1 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_