MELBOURNE SHOULDER INSTITUTE

Dr. Raf Asaid
MBBS, GDSA, FRACS, FAOrthA
Specialist Orthopaedic Surgeon

PATIENT REGISTRATION FORM

Patient Details

Mr/Mrs/Miss/Ms/Dr, other:

First name: Surname:

Address:

Suburb: Post code:

Best contact phone number:

Email address:

Date of Birth: Age:

Occupation: Sports/ Hobbies:

How did you hear about the Melbourne Shoulder Institute?
- o Doctor
- o Friend/relative
- o Internet
- o Other ……..

Medical History

Significant medical history:

Details of any previous operations:

List of all current medications being taken:

Are you taking any medications that thin the blood: Yes / No if so, please list:

Allergies (please specify):

Are you pregnant: Yes/No

Do you smoke: Yes/No

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Insurance

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ No: _ Exp: /

Veteran Affair No: _ _ _ _ _ _ Gold/ White

Private Health Insurance: Yes / No

Name of Fund:

Membership No:

WorkCover: Yes / No Claim number: Insurance company:

TAC: Yes/ No Claim number:

Medical Contact

Referring Doctor: Clinic: Phone:

Usual GP (if different): Clinic: Phone:

Usual Physiotherapist: Clinic: Phone:

Emergency Contact

In the event of an emergency, or if we are unable to contact you:

Name: Relationship:

Contact phone number:

Payment

Payment is required on the day of your visit.

All WorkCover and TAC patients are required to settle their account on the day of their consultation, and seek reimbursement from the applicable party.

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Consent

I authorise my personal and medical information to be shared with my referring medical practitioner for the primary purpose of quality health care. I consent to the handling of my information by this practice for this purpose. I declare that the statements and information supplied on this document is true and correct.

Signed: Date: