Dr Ivan Astori
Orthopaedic Surgeon
MBBS FRACS (Ortho)

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NEW PATIENT DETAILS

Surname ______ First Name ______

Preferred Name ______ Mr | Mrs | Miss | Ms | Dr | Other

Address ______
______ Postcode ______

Date of Birth ______ Age ______

Email ______

Occupation ______ Home Phone No ______

Work Phone No ______ Mobile No ______

Next Of Kin ______ Contact No ______

Medicare No ______ Ref. No ______ Exp ______

Name of person Responsible for Account ______ Ref. No ______ Exp ______

Are you eligible for Veteran's Affairs? Y | N DVA No ______

Do you have a Pensioner? Y | N Card No ______ Exp ______

Do you have private health insurance that currently covers you as a patient for treatment in a Private Hospital? Y | N

Name of Health Fund ______ Membership Number ______

Have you commenced/altered your level of cover in the last 12 months? Y | N

Is this related to a Worker's Compensation/Insurance Claim?

Claim No ______ Case Manager ______

Name of Work Cover or Insurer ______
Address/Phone ______

Name of Usual GP ______

Name of Physio ______

PATIENT CONSENT & PRIVACY POLICY FOR ASTORI ORTHOPAEDICS

Due to the Federal Privacy Act December 2001, our medical practice now requires your consent to collect personal information and a full medical history about you and sometimes others associated with your health care. Please read this information carefully and sign where indicated below.

Information regarding a patient's medical and family health history is needed to provide accurate medical diagnoses, appropriate treatment and to be proactive in your health care needs. To ensure quality and continuity of patient care your health information and information given on the patient details form may need to be shared with other healthcare providers and administrators from time to time. Information provided by the patient may also need to be provided to other allied health providers. Dr Astori is a member of various medical and professional bodies, including the Australian Medical Association. There may be occasions when disclosure of information is required for medico-legal purposes.

Therefore, before engaging the professional services of Dr Astori, you are required to give your consent to all the following areas.

I, ____, D.O.B. _________________________

(Please print name – self or parent/guardian if under 18)

consent to the following in the collection of personal information regarding my health care and associated administrative purposes.

(1) Collection of personal information included on patient detail form for administrative purposes in running our medical practice.

(2) Use of correspondence regarding my personal and health details to other healthcare providers and administrators which, from time to time, may include some but not all of the following:- radiologists, pathologists, referring general practitioners, specialists outside this medical practice and public or private hospitals.

(3) Billing purposes including compliance with Medicare, Health Insurance Commission, Worker's Compensation, Veterans' Affairs requirements and the collection of fees.

(4) I have read the information above and understand the reasons why my information must be collected and I am also aware that this practice has a privacy policy on handling information. I understand that I am not obligated to provide any information requested of me, but that my failure to do so might compromise the quality of healthcare and treatment given to me.

(5) Request for additional copies of medical correspondence will be provided with an appropriate administration charge for forwarding. A cost estimate can be provided on request.

I consent to the handling of my information by this practice for the purposes set out above.

Signature ____Date___________________________

(Please print name – self or parent/guardian if under 18)

F E E D B A C K: How did you hear about us?

☐ GP ☐ Physio ☐ Friend ☐ Internet ☐ Other

We encourage you to rate us on Rate you MD at www.ratemds.com