DR SIMON P COFFEY – ORTHOPAEDIC SURGEON M.B.B.S.(Hons) F.R.A.C.S.(Orth) F.A.O.A.

Mr Mrs Miss Ms Other

First Name_____ Initial _____Surname _____

Address_____P.Code_____

Height: _____ Weight:_____

Email address_____

Date of Birth_____ Occupation _____

Phone Home _____ Work _____Mobile _____

Next of Kin _____Relationship _____Phone _____

Medicare or DVA No _____Ref no _____Expiry date _____

Age or disability Pension No _____

Private Health Ins _____Membership No _____Ref no_____

General Practitioner (if not referring Doctor) _____

Other interested doctors_____

Current Medications_____

Allergies_____

Correspondence will usually be sent to the referring doctor, your general practitioner, physiotherapist & if necessary any other interested doctor. Are you agreeable to this? **YES / NO**

For Workers Compensation or 3rd Party cases only:

Employer _____Phone _____
Insurer _____ Claim No _____ Date of injury_____
Address _____Post Code_____
Case Manager _____Phone _____Fax _____

Privacy Statement:
As a patient of Dr Simon Coffey's, a medical record containing personal information will be maintained throughout your treatment. These records will contain information including but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information.

Settlement of your account on the day of consultation is requested. Any overdue surgical account over 2mths may be given to a collection agency (with your contact and account details) and will attract a 20% service fee plus GST unless prior arrangements have been made with this office.

I accept responsibility for my accounts and agree to the above financial conditions.

SIGNED_____**DATE**_____