

DR. AMEYA KATARIYA

DNB, Dip. Orth, MBBS

PATIENT INFORMATION FORM

Fellowship trained Hip and knee Orthopaedic Surgeon

DATE: _____

LOCATION: _____

GENERAL PATIENT INFORMATION

TITLE: (Mr / Mrs / Ms / Mst / Dr)

GIVEN NAME(S): _____

LAST NAME: _____

AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE (Home): _____ (Work): _____ (Mobile): _____

EMAIL ADDRESS: _____

OCCUPATION: _____

WHO REFERRED YOU? _____

USUAL GP DETAILS (If Different from Above): _____

PHYSIOTHERAPIST DETAILS: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship: _____

Telephone / Mobile: _____

MEDICARE / HEALTH INSURANCE INFORMATION

INSURANCE STATUS: PRIVATE PUBLIC

MEDICARE NUMBER: _____ NUMBER ON CARD: _____ EXPIRY DATE: _____

PRIVATE HEALTH FUND: _____ MEMBERSHIP NUMBER: _____

MEDICARE / HEALTH INSURANCE INFORMATION

INSURANCE STATUS: PRIVATE PUBLIC

MEDICARE NUMBER: _____ NUMBER ON CARD: _____ EXPIRY DATE: _____

PRIVATE HEALTH FUND: _____ MEMBERSHIP NUMBER: _____

You will receive a rebate from medicare to assist in the consultation fees and/or operative fees. This amount depends on the financial arrangements made. Ultimately you (or your guardian) are responsible for the account.

I understand and agree that I am responsible for payment of all charges including those not fully paid for by my insurance company.

FULL NAME: _____

SIGNATURE: _____

DATE: _____