Adelaide Shoulder & Upper Limb Clinic

P: 08 7077 0101 F: 08 7077 0109 asulc.com.au

LEADERS IN SHOULDER & UPPER LIMB SURGERY

Patient Registration Form

Family Surname: .... Given Names: ....

Date Of Birth: .... Email: ....

Address: .... Suburb: .... Post Code: ....

Home Ph: .... Work Ph: .... Mob: ....

Medicare Card No: .... Ref No (next to name):.................................... Exp Date: ....

Pension / Concession / Veterans Affairs Card Holder: O Yes O No Card No: ....

Private Health O Yes O No Name of fund: .... Membership No: ....

Does this cover you for treatment in a private hospital? O Yes O No Have you had cover for more than 12 months? O Yes O No

Family Doctor (GP): .... Suburb: ....

Referring Doctor: .... Suburb: ....

Next of kin: Name: .... Contact Ph: ....

If patient is a child (under 18) parent/guardian's full name: .... DOB: ....

Parent/Guardian's Medicare Number: .... Ref No (next to name): .... Exp Date: ....

How did you hear about Adelaide Shoulder & Upper Limb Clinic? Please tick

O Adelaide Shoulder & Upper Limb Clinic website
O Newspaper
O Google / Yahoo / Health Engine / Other
O GP referral
O Specialist referral
O Physio referral
O Trauma (A&E)
O Personal recommendation
O Self referral
O Repeat patient
O Other : ....

Why did you choose to see Dr McLean? Please tick

O Expertise listed on ASULC website
O Online reviews
O Personal recommendation
O Convenient location
O Affordable fees
O Physio/Allied Health referral
O GP referral
O Specialist referral
O Other : ....

Is this claim: a) Workcover injury O Yes O No or b) Third Party O Yes O No

Claim No: .... Injury Date: ....

Insurer: ....

Case Manager: .... Contact Ph: ....

Employer: ....

Solicitor: ....

Third party and Workcover accounts are to be paid in full on the day of consultation by the patient if the claim has not been accepted.

ACCOUNT INFORMATION

Medicare does not completely cover the cost of your consultation. The consultation fees charged by Dr McLean are as follows:

- Initial Consultation: $ 160.00
- Follow Up Consultation: $ 100.00
- Medicare Rebate: $ 72.75
- Medicare Rebate: $ 36.55

Full payment of your account is required on the day of consultation.

Financial consent: In order to maximise your Medicare Rebate, your referral to Dr McLean needs to be current and valid, otherwise Medicare will not provide you a rebate. Referrals from your GP to Dr McLean last 12 months from initial consultation. Referrals from another Specialist last 3 months from your initial consultation. If you do not have a referral or do not bring the referral to the initial appointment you are not permitted to claim a rebate from Medicare or may only be able to claim GP rates. The onus is on you, the patient/parent/guardian, to ensure your referral is kept current. If you require further information please ask our reception staff.
Privacy: In compliance with existing Privacy Legislation and consistent with maintaining confidentiality and trust with your Doctor, the Practice wishes to inform you that information collected and disclosed about you requires your consent. Why, how and who we will disclose this information to can be for the following purposes: Diagnosis and treatment of your problem including communicating with: Practice staff, specialists and other healthcare providers involved in your care; Healthcare prevention; Teaching, research and professional publications; billing and collection of professional fees; Agents that you have given authority and consent to release information to; Professional Indemnity Advisors if required. You may discuss any concerns about how we handle your information with our staff.

- I have read the above and hereby consent to the collection of information whilst in the care of this Practice.
- I understand that my care is to be undertaken by Dr McLean as an independent specialist.

Signed: .... Date: ....

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PATIENT HISTORY

This information is used to assist assessing your problem / injury

Age: .... Hand Dominance: O Left O Right Gender: O Male O Female

Nature of Employment: ....

Hobbies & Interests: ....

Do you have or have you ever had any of the following?

O Arthritis O Asthma O Diabetes O Bleeding disorder O Clotting disorder O Blood pressure (high)
O Breathing problems / shortness of breath O Chest pain / angina O Cancer O Hepatitis
O Heart attack O Heart condition O Kidney disease O Lung disease O Seizures O Stomach ulcers
O Stroke / TIAs O Thyroid disease

Are there any other conditions or diseases not listed above that you have or have had? O Yes O No O Not sure

If yes, please specify: ....

Do you have any conditions or therapies that could effect your immune system? O Yes O No O Not sure
(eg leukaemia, HIV, radiotherapy, chemotherapy, steroid therapy)

Do you smoke or vape? O Yes O No O Previously

Do you have allergies? O Yes O No O Not Sure If yes, please specify: ....

Please briefly describe your problem:

....

....

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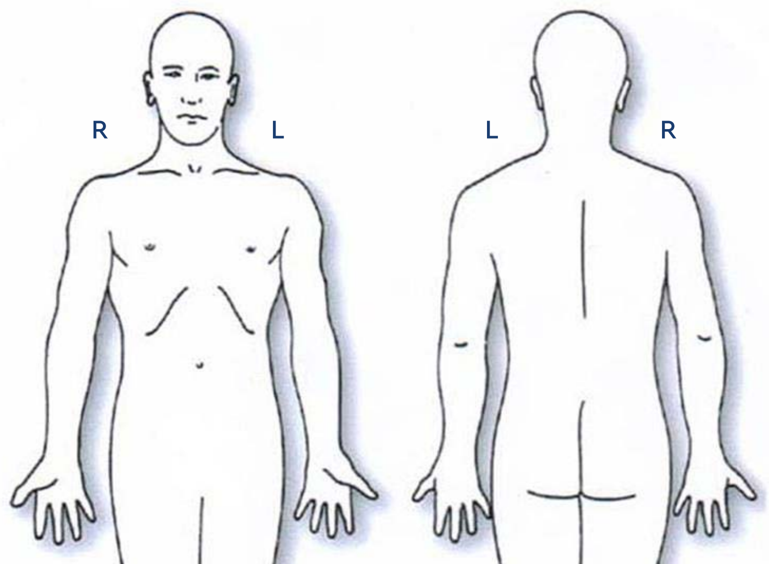

Please indicate on the diagram with an X where you feel pain.
Include all affected areas.

If your problem involved an injury, please complete the following:

1. Date & Time of Injury: ....
2. Where the injury occurred: ....
3. Brief description of the event: ....
4. Any prior Injury to this site in the past: ....
5. Names of other practitioners / physiotherapists seen for this injury: ....