PATIENT REGISTRATION FORM

Melbourne Orthopaedic Group

33 The Avenue
Windsor VIC 3181
03 9529 3333
www.mog.com.au

Title | First Name/s | Surname

Preferred Name | Email Address

Residential Address

Postal Address (if applicable)

Home Phone No. | Mobile No. | Work No.

Date of Birth / / | Occupation | Marital Status

Responsibility for Account (must be settled following consult) | Self | Parent | DVA | TAC | Workers Compensation

Next of Kin | Contact No. | Relationship

Medicare No. | Ref No. | Expiry /

Veterans Affairs No. (if applicable) | Card Colour

Referring Doctor | GP Address

Family Doctor (if different to referring Doctor) | GP Address

Health Insurance Fund | M'ship No. | Member for more than 12 months | Yes | No

Are you allergic to any medicine or tapes? | Yes | No | Details regarding allergies

Have you suffered any serious injuries in the past? | Yes | No | Details regarding past serious injuries

Have you ever been given cortisone tablets/injections? | Yes | No | Details of current medication

Details of operations in the past

Females: Are you pregnant? | Yes | No | Possibility | Have you been tested for HIV antigen | Yes | No | If yes, Positive | Negative

Do you smoke? | Yes | No | How many per day?

I agree to my medical information to be emailed to my treating medical practitioners | Yes | No | Date / /

I declare that the statements and that the information supplied on this document is true and correct. | Yes | No