



**Dr. Ben Williams**  
Orthopaedic Surgeon

**PATIENT REGISTRATION FORM**

Dr / Mr / Mrs / Ms / Miss FIRST NAME: \_\_\_\_\_ FAMILY NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

RESIDENTIAL ADDRESS: \_\_\_\_\_

POSTAL ADDRESS: \_\_\_\_\_

TELEPHONE - HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ MOBILE: \_\_\_\_\_

MEDICARE NUMBER: \_\_\_\_\_ REF: \_\_\_\_\_ EXP: \_\_\_\_\_ / \_\_\_\_\_

PRIVATE HEALTH FUND: \_\_\_\_\_ MEMBERSHIP NO: \_\_\_\_\_

HAVE YOU BEEN IN YOUR FUND LONGER THAN 12 MONTHS? YES NO N/A

VETERAN'S AFFAIRS GOLD CARD NUMBER: \_\_\_\_\_ WHITE CARD NUMBER: \_\_\_\_\_

USUAL GP NAME & PRACTICE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ TEL: \_\_\_\_\_

**IF PATIENT IS A MINOR (Under 18)** Parent/Guardian's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medicare Number: : \_\_\_\_\_ REF: \_\_\_\_\_

**WORKERS' COMPENSATION OR MOTOR ACCIDENT CLAIM** All unconfirmed workers compensation claims require payment upfront or written supporting documentation from the Employer accepting all costs of treatment.

EMPLOYER AND ADDRESS: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_ CASE MANAGER: \_\_\_\_\_

INJURY/AREA OF THE BODY TO BE TREATED: \_\_\_\_\_

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY. DO YOU HAVE A HISTORY OF?

- |                            |             |                        |
|----------------------------|-------------|------------------------|
| Heart Disease              | Asthma      | Malignant Hyperthermia |
| High or Low Blood Pressure | Diabetes    | Hepatitis              |
| Blood Clots                | Sleep Apnea | Other _____            |

**FINANCIAL INFORMATION**

Medicare does not completely cover the cost of your consultation. The consultation fee's charged by Dr Ben Williams are payable IN FULL on the day of consultation by EFTPOS only.

**Initial Consultation - \$250.00 (\$81.30 rebate)**      **Review Consultation - \$120.00 (\$40.85 rebate)**

Deviation to the above fees may occur e.g. second opinions and multiple injuries. Other fees may be incurred for plaster casts, boots, injections, splints etc. It is a term of the provision of these services that the patient shall be liable for all debt collection fees and charges, including but not limited to agent fees, solicitor costs and disbursements in the event that collection is required.

**CONSENT**

I understand that payment of the account in full is my responsibility (not applicable for accepted Workcover claims, Defence Personnel, DVA card holders). I consent to the release and communication of information from or to any other medical provider for the purpose of my ongoing clinical management, ongoing clinical care and audit.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Signature of patient or Guardian if patient is under 16 years of age)