Dr. Matthew Sharland
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	

FINANCIAL INFORMATION

Medicare does not completely cover the cost of your consultation. The consultation fee's charged by Dr Matthew Sharland 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)