

**Dr Geoff Smith**

MBChB MRCS (Ed) FRACS (Orth) FAOrthA  
ORTHOPAEDIC SURGEON

**CONFIDENTIAL PATIENT REGISTRATION FORM**

TITLE: Mr PATIENT SURNAME: [REDACTED] GIVEN NAME(S): [REDACTED]

ADDRESS: [REDACTED] PostCode 2206

Date of Birth: 04/10/1994 Telephone Hm: \_\_\_\_\_ Wk: \_\_\_\_\_ Mobile: [REDACTED]

Occupation: Electrician apprentice Email address: [REDACTED]

Medicare Number: [REDACTED] Expiry: 01/2019 Line Number (Ref): 1

Pension/Health Care Card No: [REDACTED] Type: Health care card

Health Fund: \_\_\_\_\_ Membership No: \_\_\_\_\_

Area of Treatment/Compliant (eg L Knee): ~~L Shoulder~~ Left shoulder

Parent/Guardian's Name: Fatima Ibrahim

Parent Medicare Number: \_\_\_\_\_ Expiry: \_\_\_\_/\_\_\_\_/\_\_\_\_ Line Number(Ref): \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient under 18 years of age please supply Medicare details and DOB for the Parent/Payer so we can send claim through on line to Medicare

Next of Kin Name: [REDACTED] Next of Kin Relationship: [REDACTED]

Next of Kin Telephone Number: [REDACTED]

Usual/Family Doctor/GP: [REDACTED] Telephone No: \_\_\_\_\_

Address: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Address: \_\_\_\_\_

Physiotherapist: [REDACTED]

Address: [REDACTED] Telephone Number: [REDACTED]

**Practice Privacy Policy**

This practice is, as a health provider in the private sector, bound by the National Privacy Principles and the Health Records and Information Privacy Act 2002 (NSW). These Principles set the standards by which personal information is collected from patients. A copy of these Principles is available from the Department of Health or the Australian Medical Association.  
As part of your treatment, it is usual to write to your referring Doctor, the Physiotherapist involved in your care, and any other Specialists to whom you are referred, including x-rays MRI's etc.  
In the case of compensation matters it may be necessary to write to the Insurers, Solicitor, and Employer and/or rehabilitation provider.  
As outlined in the above mentioned guidelines, only the necessary information will be released.  
For quality assurance and research, information may be extracted from you record and held on a specific secure database on occasions. It may be necessary for us to contact you for ongoing assessment.

**ALL PATIENTS TO SIGN: I HEREBY AUTHORISE THE RELEASE OF MY MEDICAL HISTORY TO MY FAMILY DOCTOR/INSURANCE COMPANY/SOLICITOR (WHERE APPLICABLE) AND TO TAKE RESPONSIBILITY FOR THE PAYMENT OF ALL ACCOUNTS PRIVATE OR INSURANCE.**

I Consent for my de identified Radiographic and Intraoperative Images to be used for Medical Education purposes

Signed:..... [REDACTED] .....

Printed Name:..... [REDACTED] ..... Date: 15/11/16

Dr GEOFF SMITH  
MBChB MRCS (Ed) FRACS (Orth) FAOrthA  
Provider Number 243619TA  
ABN: 59275536596  
ORTHOPAEDIC SURGEON

All correspondence to:  
PO Box 536  
KOGARAH NSW 1485

Address for Consultations:  
Suite 5/Level 2, 19 Kensington Street  
KOGARAH NSW 2217

Telephone: 02 9587 4720

Fax: 02 9587 6927

**To Be Completed for Workers Compensation or Third Party Claims**

**Insurance Company:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Contact Person: \_\_\_\_\_

**Claim Number:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Solicitor:** \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Accident Details:**

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Brief Description: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_