sydney sportsmedicine centre

PATIENT REGISTRATION SHEET

IMPORTANT – PRIVACY NOTICE

Information collected by us about you will be stored according to the requirements of Federal Privacy legislation. It will only be passed on where appropriate to the care of the medical problem about which you consulted us (eg to your physio or local doctor), or where legally required. If you require more information, ask a staff member to see a copy of our Privacy Policy.

○ Mr ○ Mrs ○ Miss ○ Master ○ Ms ○ Dr (Please mark) **NSW INSTITUTE ATHLETE:** ○ YES ○ NO (Please mark)

SURNAME_____ GIVEN NAME(S)_____ PREFERRED _____

DATE OF BIRTH_____/_____/_____ EMAIL ADDRESS _____

STREET ADDRESS _____

SUBURB_____ STATE_____ POSTCODE _____

TELEPHONE (H) _____ (W) _____ (Mob) _____

MEDICARE NO_____ REF No_____ EXP. DATE_____/_____ OCCUPATION: _____

REFERRAL SOURCE .(Please tick appropriate box)

☐ DOCTOR - Name_____ Address_____ REFERRAL DATE ____/____/____

☐ PHYSIOTHERAPIST – Name _____ Address_____

☐ COACH – Name _____ Sport_____ _____

How did you hear about SSMC?

☐ PRACTITIONER REFERRAL ☐ FRIEND ☐ FAMILY ☐ WEBSITE / INTERNET

☐ OTHER (Please specify)_____

COMPLETE ONLY IF APPLICABLE

☐ **WORKERS COMPENSATION CLAIM** ☐ **THIRD PARTY CLAIM** (Please mark)

NAME OF EMPLOYER_____ TELEPHONE _____

ADDRESS OF EMPLOYER_____ POSTCODE _____

NAME OF INSURANCE COMPANY_____ TELEPHONE _____

ADDRESS OF INSURANCE COMPANY_____ POSTCODE _____

CASE MANAGER_____ CLAIM NUMBER_____ DATE OF INJURY _____

NAME OF SOLICITOR_____ TELEPHONE _____

ADDRESS OF SOLICITOR_____ POSTCODE _____

PLACE OF MOTOR VEHICLE ACCIDENT _____

_____

ALL PATIENTS PLEASE COMPLETE

The above information is correct to the best of my knowledge. I have read the privacy notice above. I understand that I will be personally responsible for my accounts if any compensation claim is not accepted and/or not paid by an insurance company.

I agree for my details to be used anonymously for research purposes - ○ Yes ○ No (Please mark)

I agree to be contactable through any of the means listed above – ○ Yes ○ No (Please mark)

PATIENT SIGNATURE_____DATE_____/_____/_____

PLEASE COMPLETE

SPORT PARTICIPATION

SPORT & TIME INVOLVED PER WEEK NUMBER	LEVEL (School/Club/Social/State/National)	COACH NAME & TELEPHONE
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____