MR ANDREW GONG - ORTHOPAEDIC SURGEON

GIVEN NAMES: **TITLE:**
(as shown on Medicare card)

SURNAME: **DOB:**
(as shown on Medicare card)

ADDRESS

POSTCODE:

PHONE: (H) (W) **(MOBILE)**

MEDICARE NO: Ref No. on card (__) **VET AFFAIRS NO:**

IF PATIENT IS A CHILD, PARENT NAME: **PARENT DOB:**

PARENT MEDICARE NO: Ref No. on card (__)

PRIVATE INSUR. FUND NAME: **FUND NO:**

EMAIL ADDRESS

OCCUPATION:

REFERRING DOCTOR: Full Name:

(Address required for corres.) Full Address:

FAMILY DOCTOR: Full Name:
(if not referring doctor)
(Address required for corres.) Full Address:

TREATING
PHYSIO/CHIRO/OSTEO: Full Name:
(please circle)
(Address required for corres.) Full Address:

WORKERS' COMPENSATION (if applicable)

INSURANCE CO:

CLAIM NO: **PHONE:**

INJURY/DISEASE: **DATE OF INJURY:**

EMPLOYER NAME: **PHONE:**

ADDRESS:

TAC (if applicable) **INJURY/DISEASE:**

CLAIM NO: **DATE OF ACCIDENT:**

NOTICE ABOUT FEES: ***FIRST CONSULTATION:*** ***$220.00***
REVIEW: $***110.00***

- ***AN EXTRA FEE WILL BE CHARGED FOR INJECTIONS/ PLASTERING ETC.***
- ***WORKCOVER, TAC, DVA ACCOUNTS WILL BE SENT DIRECT IF DETAILS ARE PROVIDED.***
- ***THERE WILL BE A GAP TO PAY ON ALL ACCOUNTS*** ***(Applicable from 1/08/2017)***

PRIVACY POLICY:

I understand that this practice handles personal information in accordance with the National Privacy Principles enshrined in the Privacy Act 1988 (Commonwealth) and as outlined in the Privacy Statement. I consent to the handling of my information by this practice for the purpose of providing quality health care, associated administrative billing purposes and other treating allied health professionals e.g. Physiotherapists and Chiropractors. I also give permission for medical information to be obtained from any other source in order to help with my treatment.

Signature: **Date:**