PATIENT REGISTRATION FORM

MR ANDREI CORNOIU
Foot & Ankle Orthopaedic Surgeon

*** Please complete all 4 pages ***

1 | Patient Details

Surname: ____ Mr. | Ms. | Mrs. | Miss | Dr

Given Name/s ______________________________________ As on Medicare Card

Known As: ______________________ Date of Birth: __________________________

Address: ____

______________________________________ Post Code: ___________

Telephone: (M) _________________ (H) ________________ (W) ___________________

E-Mail Address: ____

Emergency Contact Details

Name: ____

Address: ____

Ph: _________________ Relationship to Patient: ______________________

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2 | Referrer Details

Referred By:

____

Clinic Name:

____

Regular GP & Clinic Name (*if different from referring Doctor*)

____

Physiotherapist/Podiatrist Details

Name: ________________________ Clinic: ____

Next Page: Payment Details

3 | Payment Details

MEDICARE DETAILS

Medicare Card Number

______________/__________________/_________
numbers 5 numbers 1 number

Number next to name: ___________ Expiry Date ______/________

Are you: *please tick appropriate box*:

☐ Private Patient ☐ Work Cover ☐ TAC ☐ DVA no: _________________card color__________

Private Health Insurance

Do you have Private Health Cover? ☐ Yes / ☐ No

Name of Health Insurance Fund ____

Membership Number ____

WORKCOVER DETAILS: *Note*: **AN APPROVAL LETTER IS REQUIRED TO CLAIM WITH WC**

Insurance Company ____

Claim Number ______________________________

Employer Name ____

Employer Address ____

Date of Injury ______________________________

TRANSPORT ACCIDENT COMMISSION - TAC

Claim Number ______________________________

Date of Injury ______________________________

CURRENT FOOT & ANKLE PROBLEM

Have you suffered an injury? ☐ Yes ☐ No

When (approximate date)? ____________________________

How? ____

Next Page: General Medical History

GENERAL MEDICAL HISTORY

Occupation ______________________________

Do you smoke? ☐ Yes ☐ No If Yes…How much & for how long? ________________

Are you an ex-smoker? ☐ Yes ☐ No If Yes…Please give details ______________________

Do you drink Alcohol? ☐ Yes ☐ No If Yes…How much? ____________________________

Do you suffer from any of the following? *Please circle the appropriate*

Anxiety or Depression	Diabetes	Hepatitis	Skin Disorder
Asthma	Embolism	HIV / Aids	Strokes
Arthritis	Emphysema	Kidney Stones	Transfusions
Bleeding Disorder	Gastrointestinal Disorder	Leg Clots	Ulcers
Blood Clots	Gout	Pneumonia	Vascular Disease
Bronchitis	Heart Attack	Osteoporosis	
Cancer	Other Heart Problems	Other Lung Problem	
Congenital Disorder	High Blood Pressure	Rheumatoid Arthritis	

Other Diseases

____

____

Do you take any Medications: ☐ Yes ☐ No If Yes…What Medications do you take?

____

____

Are you Allergic to any Medication? ☐ Yes ☐ No If Yes…Please List

____

____

Your weight: ____________ (kg)

Have you had SURGERY IN THE PAST RELEVANT TO THIS CONSULTATION: ☐ Yes ☐ No

Type of Surgery	*Approx Date*	*Surgeon / Hospital*

Next Page: Informed Financial Consent

CONSULTATION FEES:

INITIAL CONSULTATION: $220.00
SUBSEQUENT CONSULTATION: $120.00

FEES TO BE PAID ON THE DAY OF CONSULTATION

(We accept Visa / MasterCard / EFTPOS /Cash)

A Medicare Rebate will be submitted on your behalf, and you will receive the following rebates:

- $84.15 Initial Consultation
- $42.30 Subsequent Consultations

A GP or specialist referral to Mr Cornoiu is required to receive the rebate.
For **WorkCover patients** the fee will be required on the day unless an approval letter is received.

Please note important information: If you "No Show" to your appointment without any prior notice either by phone or email, you will be required to pay initial consultation fee of $220.

By signing below, you accept the terms and conditions.

Patient Signature: ____ Date: __________________________