DR PETER LAM – Foot & Ankle Orthopaedic Surgeon

Member Australian & American Orthopaedic Foot & Ankle Societies
Fellow Royal Australian College of Surgeons

PATIENT REGISTRATION FORM

Miss Mrs Ms Mr Master (please circle)

Surname:..... Given Names:.....

Address:.....

Suburb:..... Postcode:.....

Date of Birth:..... Occupation:.....

Phone: Home..... Work.....

Mobile:..... Email:.....

Health Fund:.. ..... Member No:.....

Medicare No: __ __ __ __ __ __ __ __ __ __ Exp: __ __/__ __ __ __ Ref No: __

Veteran's Affairs (DVA) No: ..... Please circle: Gold or White Card

Pension Card No: __ __ __ __ __ __ __ __ __ __ Exp: __ __/__ __/__ __ __ __

MEDICAL HISTORY

Medical Conditions:.....

.....

Medications:.....

.....

Allergies:.....

Anaesthetic (list personal &/or family problems):.....

.....

WORKERS COMPENSATION/MOTOR VEHICLE ACCIDENT CLAIMS (if applicable)

Date of Injury:..... Claim No:.....

Insurance Co:.....

Address:..... .....

Phone:..... Contact:.....

Employer:.....

REFERRAL INFORMATION

Your Local Doctor **if different to your referral**:.....

Address:..... .....

Physio:.....Address:.....

Podiatrist:.....Address:.....

PRIVACY ACT CONSENT

I have read the Privacy Act Consent information (as listed on website) regarding the handling of my information by this Practice for the purposes set out in that form. I consent to the handling of that information subject to any limitations on access or disclosure about which I notify this Practice.

Signed:.....Parent/Guardian:.....

Date:.....