RICHARD DALLALANA
SHOULDER & ELBOW SURGEON
MBBS FRACS FAOrthA

Park Clinic ORTHOPAEDICS

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PATIENT INFORMATION

Dr/Mr/Mrs/Ms/Miss/Mstr

SURNAME: _____ GIVEN NAME(S): _____

DATE OF BIRTH: _____/_____/_____ OCCUPATION: _____

ADDRESS: _____ Post Code : _____

EMAIL ADDRESS: _____

TELEPHONE: HOME: _____ MOBILE: _____

PERSON RESPONSIBLE FOR ACCOUNT: (Parent or Guardian) _____

NEXT OF KIN: (Name & Phone Number) _____

REFERRING DOCTOR: _____

FAMILY DOCTOR : (if different to above) _____

PHYSIOTHERAPIST : (name and location) _____

MEDICARE NUMBER: _____ Reference Number : _____

PRIVATE HEALTH FUND: _____ Membership Number : _____

WORKCOVER or TAC:

CLAIM NUMBER: _____ DATE OF INJURY: _____

INSURER (e.g. Allianz, CGU) : _____

MEDICAL CONDITIONS / RECENT SURGERY :

_____

_____

_____

_____

_____

CURRENT MEDICATION (Include blood thinners or aspirin) :

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: _____

_____

FEES : New Consultation $250.00 ; Subsequent Consultations $120 ; WorkCover and TAC First Attendance $300.00

CONSENT : I consent to the confidential handling of this information and to abide by the payment terms of this practice.
I consent to the use of de-identified clinical and operative images for the purpose of research, teaching and case discussion

SIGNED: _____ DATE: _____