Mr Troy Keith - Orthopaedic Foot & Ankle Surgeon and Trauma Surgeon

Name ..... DOB: ..... / ..... / .....

Address ..... Occupation: .....

Phone (M)..... (Other Ph) .....

Email:

Medicare__ __ __ __ __ __ __ __ __ __ (__) Exp: __ / __ DVA: .....

MUST be 10 numbers + number next to Patient name on card

Health Insurance (Company) ..... Member Number: .....

Next of Kin: ..... Phone: .....

Injury/Problem ..... Side: (Please circle) **RIGHT** **LEFT**

Other Injury (please list) .....

Referring Doctor Name: .....

Clinic: .....

Usual GP Name: .....

Clinic: .....

Did the Hospital Emergency Department refer you? (IF YES)

Doctor Name/Hospital: .....

Physiotherapist: .....

Do you have Orthotics? YES NO Made by: .....

Please indicate any Illnesses or Conditions you have had: (Please circle)

Heart trouble / Cancer / Asthma / Stroke / High Blood Pressure / Nervous disorder / Bleeding problems / Diabetes

Any previous surgery(s).....

Do you smoke? YES NO Packs per week:..... Are you an **Ex-smoker** YES NO

Any allergies? YES NO Are you taking blood thinners? Aspirin / Warfarin / Other

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FEES AND PRIVACY POLICY:

INITIAL CONSULTATION: $195 (Medicare rebate applies) **REVIEW: $95** (Medicare rebate applies)

* AN EXTRA FEE WILL BE CHARGED FOR ANY INJECTIONS GIVEN BY THE DOCTOR
* WORKCOVER, TAC, DVA ACCOUNTS ETC WILL BE SENT DIRECT IF DETAILS ARE PROVIDED (Provided we have full details and claim number)
* IF ACCOUNT IS OUTSTANDING OVER 30 DAYS IT MAY BE REFERRED TO DEBT COLLECTION AGENCY. ANY FEE INCURRED IN WILL BE PASSED ONTO THE PATIENT

I understand that this practice handles personal information in accordance with the National Privacy Principals 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, associate administrative billing purposes and other treating allied health professionals e.g. Physiotherapists. I also give permission for medical information to be obtained from any other source in order to help with my treatment.

I HAVE READ AND UNDERSTAND THE ABOVE FEES PAYABLE AND PRIVACY POLICY

Signature _____ Date _____

ACCOUNT HOLDER – If patient is under 16 **OR** if a parent/guardian is paying the account - This info is needed for M/C claiming.

Name: ..... Ref on M/C ..... DOB: .....

Please complete with the details of the person paying the account (Eg. Mother/Father/Guardian) - If this person is on a separate M/C card - please supply FULL details.