Dr. Sam Adie
BSc(Med) MBBS(Hons) MSpMed MPH PhD
FRACS(Ortho) FAOA
Orthopaedic and Trauma Surgeon
Hip, Knee, Foot & Ankle Reconstruction
Provider Number 274348GA
ABN 50883316250

St. George SportsMed
Orthopaedics and Sports Medicine

TITLE: _____ PATIENT SURNAME: _____ GIVEN NAME(S):_____

ADDRESS: _____ Post Code: _____

Date of Birth: ____/_____/_____ Telephone Hm: _____Wk: _____ Mobile: _____

Occupation: _____ Email address: _____

Medicare / DVA Number: _____ Expiry: _____ Line Number (Ref):_____

Aged Pension Card No: _____

Health Fund: _____ Membership No: _____

Area of Treatment/Complaint (*eg. Left Elbow*):_____

If patient under 18 years of age please supply Medicare details and DOB for Parent/Payer so we can send claim online to Medicare

Parent/Guardian's Name: _____

Parent Medicare Number: _____ Expiry: ____/____ Line Number (Ref): _____DOB:____/_____/____

Next of Kin Name: _____ Next of Kin Relationship: _____

Next of Kin Telephone No: _____ Contact Next of Kin after Surgery? Yes / No

Usual/Family Doctor/GP: _____ Telephone No: _____

Address: _____

Referring Doctor: _____ Telephone No: _____

Address: _____

Physiotherapist: _____

Address: _____ Telephone No: _____

Practice Privacy Policy

This practice is, as a health provider in the private sector, bound by the National Privacy Principles and the Health Records and Information Privacy Act 2002 (NSW). These Principles set the standards by which personal information is collected from patients. A copy of these Principles is available from the Department of Health or the Australian Medical Association.

As part of your treatment, it is usual to write to your referring Doctor, the Physiotherapist involved in your care, and any other Specialists to whom you are referred, including x-rays MRI's etc.

In the case of compensation matters it may be necessary to write to the Insurers, Solicitor, and Employer and/or rehabilitation provider.

As outlined in the above mentioned guidelines, only the necessary information will be released.

For quality assurance and research, information may be extracted from you record and held on a specific secure database on occasions. It may be necessary for us to contact you for ongoing assessment.

ALL PATIENTS TO SIGN: I HEREBY AUTHORISE THE RELEASE OF MY MEDICAL HISTORY TO MY FAMILY DOCTOR/INSURANCE COMPANY/SOLICITOR WHERE APPLICABLE) AND TO TAKE RESPONSIBILITY FOR THE PAYMENT OF ALL ACCOUNTS PRIVATE OR INSURANCE.

I DO / DO NOT Consent for my de identified Radiographic imaging data and Intraoperative Images to be used for Teaching, Medical Education and Research purposes including computer modelling.

Signed:.....

Printed Name:..... **Date:** ...../...../..... **PTO**

Medical History

	Please tick			Please tick	Other:
High cholesterol	☐	Diabetes	Type 1	☐	
High Blood Pressure	☐		Type 2	☐	
Heart Attack / Angina	☐	Cancer		☐	
Cardiac stent	☐	Reflux		☐	
Coronary Bypass Surgery	☐	Liver disease		☐	
Heart valve surgery	☐	Kidney Disease		☐	
Stroke / TIA	☐	Bleeding disorder		☐	
Epilepsy	☐	DVT		☐	
Lung disease	☐	Pulmonary Embolus		☐	
Previous ECHO scan	☐				

Medication	Dose	Frequency	Medication	Dose	Frequency
Oral contraceptive?					
Hormone replacement?					

Allergies	Please tick	Name	Type of Reaction	Alcohol **Please tick**	Smoking **Please tick**	
Antibiotics	☐			□ Yes	□ Never	
Dressings	☐			□ No	□ Prior	**When Stopped**
Iodine	☐				□ Yes	**No. per day**
Other	☐					

Other Treating Specialists: eg.Cardiology, Respiratory, Neurologist	Problems with prior anaesthetics	Other Problems with prior surgery

To Be Completed for Workers Compensation or Third Party Claims

CLAIM NUMBER	Insurance Company	Employer	Solicitor
Address:			
Contact Person			
Phone / Fax / Email			
Accident Details Brief Description:			Date of Accident: ____/_____/____

Signature:_____ Print Name:_____ Date: _____/_____/_____

St George SposrtsMed
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