Dr Andrew Higgs

MBBS MSc FRACS FAOrthA.
Orthopaedic Surgeon

PATIENT INFORMATION

Mr Mrs Miss Ms Dr Sr Br (Please circle)

Given Names: ……Surname: .....

Address: ……Postcode……

Phone: (H): ……..(W): …….. (M): ……

Date of Birth: ……Occupation: ……

Email Address: ……..

Referring Doctor: ……..

Local Doctor: ……Address: ……..

Brief description of your problem: ……..

……..

NEXT OF KIN: Name…… Relationship…… Phone……..

PHYSIOTHERAPY/PODIATRY (if you require a copy of your correspondence to be sent to your physio/podiatrist)

Name: …… Phone: …… FAX: …….

Address: …….

PRIVATE INSURANCE (YES/NO)

Health Fund Name: …… Health Fund Number ……..

Medicare Card Number: ……..Reference No (next to name on card)…….. Expiry Date: ……

Pension Number:……Expiry Date:……..

If Veteran, DVA Number: ……

WORKERS COMPENSATION DETAILS/THIRD PARTY (If appropriate)

Insurance Company: …… Claim Number: ……

Date of Injury: …… Contact:……

Address: …….. Telephone No: ……..

Employer's Name. …… Contact ……

Address: …… Telephone Number …….

The above details are true to the best of my knowledge and permission is hereby given to release medical details to my local doctor, Insurance Company and other medical providers upon request. I also give Dr Higgs permission to access any of my medical records that he requires. In addition, I understand certain information may be used for medical research and audit purposes.

SIGNED: ……Date: ……