Mr David R J Gill
MB ChB, FRACS FAOrthA
Orthopaedic Surgeon
Shoulder, Elbow & Wrist Surgery
Joint Replacement

NEW PATIENT FORM

First Name: ……..Dr/Mr/Mrs/Ms Surname:……

Date of Birth: _____ / _____ / _____ Occupation: ……

Phone (Home): …… Phone (Work/Mobile): ……

Residential Address : ……

……

Mailing Address(if different)……

Email:……

Referral Details

Who has referred you to Mr Gill?……

……

Family Doctor(if different from referring Doctor):……

Practice Name: ……

Medicare No.:……Ref No.:……Exp. Date:……
(Number before your name)

Do you have Private Hospital Insurance? YES ☐ NO ☐

If yes, which fund are you with?……

Membership No.:……

When did you join the fund (only complete if within last two years)?……

DVA Veteran's Affairs No. if applicable:……

Have you ever had Hepatitis? YES ☐ NO ☐ List Allergies if any:……

……

Consent

I provide my consent for Mr Gill, Orthopaedic Surgeon, to collect and use my medical information for the purpose of Research & providing accurate medical treatment with written reports to my referring Doctor.

Signature: ……. Date: ……

FOR WORKERS' COMPENSATION INJURY

Insurance Company:…… Claim No…….

Name of Employer: ……

Date of Accident: ……

Declaration: I,……..will be responsible for payment of all accounts if liability is denied or disputed by the Insurer.