

# DR JULIAN YU

BMed FRACS (Orth) FAOrthA  
CONSULTANT ORTHOPAEDIC SURGEON  
SPECIALIST HIP AND KNEE SURGEON

## PATIENT INFORMATION FORM

DATE: \_\_\_\_\_

LOCATION:  Dee Why  Chatswood  City

### GENERAL PATIENT INFORMATION

TITLE: (Mr / Mrs / Ms / Mst / Dr)

GIVEN NAME(S): \_\_\_\_\_

LAST NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Mobile): \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_  GP  Specialist  Friend  Other

USUAL GP DETAILS (If Different from Above): \_\_\_\_\_

PHYSIOTHERAPIST DETAILS: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone / Mobile: \_\_\_\_\_

### MEDICARE / HEALTH INSURANCE INFORMATION

INSURANCE STATUS:  PRIVATE  PUBLIC  WORKERS COMPENSATION  DEFENCE  3<sup>RD</sup> PARTY

MEDICARE NUMBER: \_\_\_\_\_ NUMBER ON CARD: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_\_

PRIVATE HEALTH FUND: \_\_\_\_\_ MEMBERSHIP NUMBER: \_\_\_\_\_

PENSION:  Yes  No PENSIONER NUMBER: \_\_\_\_\_

VETERANS AFFAIRS (DVA) NUMBER: \_\_\_\_\_ TYPE:  White  Gold

(If This is a Workers Compensation Case, Please Inform the Staff to Fill In Additional Form)

### AUTHORISATION FOR RELEASE OF INFORMATION & PAYMENT INFORMATION

It is the usual practice to write to your referring doctor and any specialists involved in your care. Furthermore, it may be necessary to write to your Workers Compensation, 3<sup>rd</sup> Party or rehabilitation provider.

Payment is Requested At the Time of Consultation

You will receive a rebate from medicare to assist in the consultation fees and/or operative fees. This amount depends on the financial arrangements made. Ultimately you (or your guardian) are responsible for the account.

*I understand and agree that I am responsible for payment of all charges including those not fully paid for by my insurance company.*

FULL NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_