Dr Darren Waters – Orthopaedic Surgeon
Specialising in Shoulders, Hips,
Knees, and Ankle, Joint Replacements

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PATIENT REGISTRATION FORM

FAMILY SURNAME: .....

GIVEN NAMES: Dr / Mr / Mstr / Mrs / Ms / Miss .....

DATE OF BIRTH: __ __ / __ __ / __ __ __ __ AGE: ..... OCCUPATION: .....

ADDRESS: .....

SUBURB: ..... POST CODE: __ __ __ __

TELEPHONE - HOME: __ __ __ __ __ __ __ __ MOBILE: __ __ __ __ __ __ __ __ __ __ WORK: .....

PRIVATE EMAIL: .....

MEDICARE CARD NUMBER: __ __ __ __ __ __ __ __ __ __ REF NO: __ (number next to name) EXPIRY DATE: __ __ / __ __ __ __

AGED PENSION / DVA CARD HOLDER: YES / NO CARD NO: ..... EXPIRY DATE: __ __ / __ __ __ __

DO YOU HAVE PRIVATE HOSPITAL COVER: YES / NO DATE JOINED: __ __ / __ __ / __ __ __ __

FUND NAME: ..... **MEMBERSHIP NO:** .....

NEXT OF KIN – Name: ..... Relationship to Patient: ..... Contact no: .....

REFERRING DOCTOR: ..... CLINIC: .....

ADDRESS: ..... SUBURB: .....

FAMILY DOCTOR (if different): ..... CLINIC: .....

ADDRESS: ..... SUBURB: .....

Please complete the following Information if this relates to a Work Cover Injury/Claim

IS THIS CLAIM A WORK COVER INJURY: YES / NO INSURER: .....

CLAIM NO: ..... INJURY DATE: __ __/ __ __ / __ __ __ __

CASE MANAGER: ..... CONTACT NO: .....

EMAIL: .....

EMPLOYER: ..... CONTACT NO: .....

**** Please note, Dr Darren Waters DOES NOT see Public Liability, Third Party or MVA. Claims**
**** Please note, although this may be a claim, the final responsibility for payment falls on the patient**

General information and Fees

Medicare does not completely cover the cost of your consultation. The consultation feed charge by Dr Waters are as follows:

Initial Consultation	**$200.00**	**Subsequent Consultation**	**$100.00**
Pensioner	**$150.00**		**$100.00**
Medicare Rebate	$88.40		$44.45

I understand that my care is to be undertaken by Dr Waters as an independent specialist. In engaging Dr Waters I acknowledge that my contractual relations are with the Medical Practitioner.
I consent to audio visual material being taken during my treatment and I have access to this (arthroscopic photos). This material may be used for clinical teaching and research and stored electronically.
I understand that payment in full of the account is my responsibility and a gap will be charged above the Medicare Rebate. Failure to pay accounts will result in legal action/debt collection which incurs an additional charge payable by myself.
Dr Waters has a financial interest in several Hospitals in South Australia and this may include the provision of imaging, pathology, physiotherapy and other medical services.

Signed: ..... **Date:** __ __ / __ __ / __ __ __ __

PLEASE TURN PAGE OVER

PATIENT HISTORY

This information is to assist Dr Waters in assessing your injury.

1. Date and Time of Injury or Complaint:

2. Where did the injury occur:

3. Brief description of the event:

4. Treatment sought immediately after incident i.e. GP opinion, physio etc.:

5. Names of other practitioners seen for this injury:

6. Investigations undertaken i.e. X-rays, MRI, blood tests etc.

7. Physiotherapists name

8. Any prior Injury to this site in the past.

9. Expectations in regards to work and or sports:

10. Allergies.

Description of injury or injuries (please use diagram to indicate where you feel pain - please include ALL affected areas)

Please mark on the diagram the site of pain.

Also, mark your worst pain with an X

