Dr. Brett Fritsch
Orthopaedic Surgeon

Patient information Sheet

The (Knee) Institute
Landmark Orthopaedics

Please Circle: Dr / Mr / Mrs / Ms / Miss / Master

Given Name/s: _____ **SURNAME:** _____

Preferred name: _____ **Street Address:** _____

Suburb: _____ **P/Code:** _____ **DOB:** __ __ / __ __ / __ __ __ __

Home Phone: _____ **Work:** _____ **Mobile:** _____

Email address: _____

Medicare no: ___ ___ ___ ___ __ ___ ___ ___ ___ ___ (10 digits) **Medicare reference no:** _____

IF THE PATIENT IS UNDER 18 YEARS OF AGE, PARENT/GUARDIAN TO FILL IN YOUR NAME AND DETAILS BELOW:

Name: _____ ***DOB:*** __ __ / __ __ / __ __ __ __

Your Medicare reference no: _____

Health Fund Name: _____ **Membership no:** _____

Blue Pension Card no: _____ **Expires:** __ __ / __ __ / __ __ __ __

Veteran's Affairs (DVA) no: _____ **Gold or White** (please circle)

Your Family Doctor: _____ **Phone:** _____

Your Family Doctor's Address: _____

Your Physiotherapist's Name: _____ **Tel:** _____

Address: _____

Your Occupation: _____ **Are you required to perform any physical labour at work?**: YES / NO

Please describe your duties: _____

Name of emergency contact person: _____ **Relationship to you:** _____

Their contact phone number: _____

Your Medical conditions: _____

Medications: _____

Allergies: _____

I give CONSENT for my information given to this Practice to be used for the purposes of collecting and disclosing to others to assess, diagnose and treat illness now or at any future time.

Signed: _____ **Date:** __ __ / __ __ / __ __ __ __

Patient Name: _____ **Guardian/Parent's Name:** _____

****

WORKERS' COMPENSATION/THIRD PARTY DETAILS: (if applicable)

Injury Date: __ __ / __ __ / __ __ __ __ **Claim no:** _____

Employer's Name: _____ **Contact Person:** _____

Address: _____ **Tel:** _____

Insurance Co: _____ **Contact Person:** _____

Address: _____ **Tel:** _____