

DR ANDREW M ELLIS
MBBS FRACS (Orth) FAOrthA
Orthopaedic Surgeon

Mr /Mrs /Miss /Ms /Dr/Prof _____

Surname _____ Given names _____

Address _____

Telephone (H) _____ (W) _____ Mobile _____ Fax _____

Date of birth / / Age _____ Occupation _____

If Child: Contact parent name _____ Mobile _____

Account to _____

Referring doctor _____ Phone _____

Address _____

General Practitioner _____ Phone _____

Address _____

Medicare Number _____ Ref _____ Exp _____ Veteran's Affairs Number _____

Pension/Health Care Card Number _____ Expiry date / /

Do you have private health insurance? Yes No If yes, please indicate your fund below.

MBF HCF Medibank Private NIB Manchester Unity Other

Name of Other _____ Membership Number _____

Please tick one of the following if applicable.

Workers Compensation Third Party Public Liability

Claim number _____

Insurance company _____ Contact name _____

Address _____

Telephone _____

Solicitors _____ Contact name _____

Address _____

Telephone _____

Workers Compensation Only

Employer _____ Contact name _____

Address _____

Telephone _____

ALL PATIENTS TO SIGN PLEASE

Permission is given to release the medical history to the family doctor, insurance company or solicitor (where applicable) and I agree to take responsibility for the payment of my accounts.

Signature _____ Date / /