Mr John E Cunningham OAM
BSc(Hons) MBBS MClinEpi FRACS FAOrthA
Orthopaedic Spine Surgeon

PATIENT REGISTRATION

NAME: Mr/Mrs/Miss/Ms/Mr ....

ADDRESS..

....POSTCODE.................................

PHONE: Mobile.......................................Home.......................................Work.......................................

EMAIL ADDRESS:..

DATE OF BIRTH:...

OCCUPATION:...

NEXT OF KIN:..CONTACT NO:..

MEDICARE NO:..DVA NO..

PRIVATE INSURANCE...MEMBERSHIP NO:.......................................

REFERRING DOCTOR:..

ADDRESS..

....POSTCODE...

LOCAL DOCTOR:..PHONE NO:................................

ADDRESS:..

IF THIS IS A WORKCOVER / TAC CLAIM PLEASE PROVIDE DETAILS:

Employer's Name & Address..

....

Insurance / or Solicitor's Company:...

Address...

Phone:.......................................Fax:...................................Email..

Claim No:...*Date of Injury:*..

PRIVACY STATEMENT To provide a high standard of medical care we need to collect personal information from our patients. We are committed to protecting the privacy of patient information and to handling your personal information in a responsible manner. All persons accessing your personal health information are bound by confidentiality. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. To do this we use various communication methods including email, fax and postal services. Appointment and health reminders will be sent via SMS and or email.

□ Do not send reports to My Health Record

SIGNATURE:...NAME:..

DATE:..