

Please complete all pages and sign.

Mr  Mrs  Miss  Ms  Mx  Dr  (Please tick) Surname \_\_\_\_\_

Given Names \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Suburb \_\_\_\_\_ Postcode \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Parent/Guardian Full Name (If under 18) \_\_\_\_\_ DOB \_\_\_\_\_

Medicare No. 

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Reference No. (Next to Name) 

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Reference No. (Parent/Guardian) 

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Private Health Insurance (Please tick) Yes  No

Fund Name \_\_\_\_\_ Member No. \_\_\_\_\_

Pension Card No. \_\_\_\_\_ Expiry \_\_\_\_\_

Veterans' Affairs Card No. \_\_\_\_\_ Colour \_\_\_\_\_ Expiry \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Practice/Suburb \_\_\_\_\_

Usual GP (If not referring doctor) \_\_\_\_\_ Practice/Suburb \_\_\_\_\_

Physiotherapist \_\_\_\_\_ Practice/Suburb \_\_\_\_\_

### Next of Kin

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### Injury Details

Injured body part (right/left) \_\_\_\_\_

Date of injury \_\_\_\_\_ Duration of symptoms \_\_\_\_\_

Current diagnosis \_\_\_\_\_

Treatment so far \_\_\_\_\_

### Imaging Details

Scan (eg, X-ray, MRI) \_\_\_\_\_ Provider (eg, PRC, SKG, Envision) \_\_\_\_\_

Scan (eg, X-ray, MRI) \_\_\_\_\_ Provider (eg, PRC, SKG, Envision) \_\_\_\_\_

Scan (eg, X-ray, MRI) \_\_\_\_\_ Provider (eg, PRC, SKG, Envision) \_\_\_\_\_

### Previous Orthopaedic Surgery

Body part \_\_\_\_\_

Operation \_\_\_\_\_

Surgeon \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Issue \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking an injectable diabetes or weight loss medication? (Please tick) Yes  No   
If so, which one? (Common names: Ozempic, Wegovy, Victoza, Saxenda, Trulicity, Mounjaro, Semaglutide)

Height \_\_\_\_\_ Weight \_\_\_\_\_

Smoker (Please tick) Yes  No  How many years \_\_\_\_\_

Drug allergies \_\_\_\_\_

COVID-19 vaccination status First dose  Second dose  Third dose

### Complete only if workers compensation or motor vehicle accident

Date of injury/accident \_\_\_\_\_ Type of injury \_\_\_\_\_

How did the injury occur? \_\_\_\_\_  
\_\_\_\_\_

Insurance company \_\_\_\_\_ Claim No. \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Suburb \_\_\_\_\_ Postcode \_\_\_\_\_

Name of solicitor (If any) \_\_\_\_\_

### All patients please sign

I, \_\_\_\_\_ authorise the release of Clinical information and Reports relating to my condition as treated by Coastal Orthopaedic Group. In the event that my claim is rejected I accept that it is my responsibility for settling all accounts with Coastal Orthopaedic Group.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT PRIVACY CONSENT FORM

Coastal Orthopaedic Group is committed to maintaining the privacy of our patients. In order to safely and effectively provide you with the best care possible, we may collect, use and store personal and health information from you and other health professionals involved in your care.

Coastal Orthopaedics may also need to provide your personal or health information to others (such as specialists or other members of your care team) so you receive quality and effective care.

We may also use personal information as part of our billing and administrative processes, in order to comply with Medicare and Health Insurance Commission Requirements.

Coastal Orthopaedics may use an AI transcription tool to generate notes from your consultation, to be used for patient file notes or correspondence. This software records your consultation and generates written notes which our providers then check for accuracy before saving the final version to your patient file. The transcription tools may store de-identified and encrypted patient information (on Australian servers) for no more than one month.

A copy of our full Privacy Policy is available on our website. The Privacy Policy contains information about obtaining and updating your personal information, how we deal with your personal and health information and how you may raise any concerns or make a complaint.

### Your Acknowledgement

- I acknowledge and agree to Coastal Orthopaedics collecting, using and storing my personal and health information in accordance with this consent form and Coastal Orthopaedics' Privacy Policy.
- I consent to Coastal Orthopaedics generating consultation notes using AI transcription tools.
- I agree to Coastal Orthopaedics communicating with me by email. I understand that email communication is not a secure method of communication but that any email communication from Coastal Orthopaedics which contains sensitive information will be flagged confidential.

Patient name \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_