PATIENT REGISTRATION

DR SIMON ZILKO
ORTHOPAEDIC FOOT + ANKLE SURGEON

PERSONAL DETAILS

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other **Date of Birth:** _____/_____/_____

Surname: _____ **First Name:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Email: _____

Occupation: _____

Telephone Numbers:

Home: _____ Work: _____ Mobile: _____

Next of kin details (family member or friend / medical power of attorney)

Name: _____ Relationship to you:_____

Contact number: _____

CLAIM DETAILS

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Ins: ☐ Yes ☐ No Fund Name: _____ Fund Number: _____

Concession Cards:

Aged or Disability Pension No: _____ Exp Date: _____

Dept. Veterans Affairs Card No: _____ ☐ White ☐ Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

Defence Force: Entitled Persons No: _____

WorkCover (If applicable) Claim No: _____ Insurer: _____

ICWA (Motor Vehicle) (If applicable) Date of Accident: _____ Claim Number: _____

Usual GP Name: _____ GP Provider Number: _____

Practice details: _____

PLEASE TURN OVERLEAF

FRACS Fellow of the Royal Australasian College of Surgeons
FAORTHA Fellow of the Australian Orthopaedic Association

DR SIMON ZILKO | Consultant Orthopaedic Foot & Ankle Surgeon
Suite 13 Wexford Medical Centre, 3 Barry Marshall Pde, Murdoch WA 6150
All Enquiries Tel: 08 9489 8700 Fax: 08 9381 8300 Web: www.drsimonzilko.com.au

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ORTHOPAEDIC FOOT + ANKLE SURGEON

AUTHORISATION AND CONSENT TO PHOTOGRAPHY/VIDEO

I, _____ hereby consent that photographs be taken of me by Dr Simon Zilko.

Dr Simon Zilko at all times respects patients' right to privacy and informed consent for procedures within the practice including photographic records. I understand that these photographs form an essential part of my medical record as well as my preoperative and postoperative assessment. I understand and consent to my photographs being used by Dr Simon Zilko for medical research, teaching and or patient education purposes. I understand that I will not be identified by name in any such use of these photographs, however in some circumstances the photographs may portray features that shall make my identity recognisable.

I give permission for Dr Simon Zilko or his staff to contact me by telephone and if necessary leave a message. I have read all of the above and all my questions have been answered.

Signature: _____ **Date:** ____/____/_____

HEALTH RECORDS ACT 2001 COLLECTION STATEMENT

Dr Simon Zilko is collecting your health information in order to provide you with health services. Please read and sign to give approval for this information to be collected and stored. Your medical information will be used exclusively for providing health care in the following way:

- To gain a history, diagnose disease and provide treatment where necessary;
- Administrative purposes in running this Practice, which may also include confirmation of your appointment.
- Writing reports to your Doctor and other Doctors involved in the provision of healthcare, and the storing of reports provided to this Practice by other Medical Specialists; and
- Billing and collection purposes, including but not limited to compliance with Private Health Fund, Medicare and Health Insurance Commission requirements. You may gain access to your health information by writing to us. If you do not consent to providing us with your health information we may be unable to provide you with health services.

I consent to Dr Simon Zilko collecting my health information.

Signature: _____ **Date:** ____/____/_____

REFERRAL SOURCE

How did you hear about Dr Simon Zilko? Referred by Doctor ☐ GP or ☐ Specialist

☐ Australian Orthopaedic Association website ☐ Royal Australian College of Surgeons website

☐ Google ☐ Personal Recommendation: _____

☐ Other: _____

ALL CONSULTATIONS ARE PAYABLE AT THE TIME OF SERVICE.
Unfortunately, we do not bulk bill, however for your convenience we can accept EFTPOS, Visa, MasterCard, cheque and cash.

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