DR SIMON ZILKO
ORTHOPAEDIC FOOT + ANKLE SURGEON

PATIENT REGISTRATION

PERSONAL DETAILS

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

First Name: _____ **Known As:** _____ **Surname:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Email: _____

Telephone Numbers:

Mobile: _____ Home: _____ Work: _____

Emergency Contact Details (eg NOK, POA): Name: _____

Contact number: _____ Relationship to you: _____

Parent's details if patient is a minor (required for Medicare):

Name: _____ Date of Birth: _____/_____/_____

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

ARE YOU FULLY VACCINATED AGAINST COVID-19: ☐ Yes ☐ No

Please attach your COVID-19 certificate with this patient registration

CLAIM DETAILS

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

Private Health Insurance: ☐Yes ☐No With Hospital Cover: ☐Yes ☐No

Fund Name: _____ Fund Number: _____

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

Defence Force: Entitled Persons No: _____

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

Date of Injury: _____/_____/_____ Employer: _____

Employer's Address: _____

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

Usual GP Name: _____

GP Practice details: _____

FAORTHA FELLOW of the AUSTRALIAN ORTHOPAEDIC ASSOCIATION

Dr Simon Zilko ABN 35 192 898 398
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E admin@drsimonzilko.com.au
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3 Barry Marshall Pde,
Murdoch WA 6150

Hollywood Medical Centre
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AUTHORISATION AND CONSENT TO PHOTOGRAPHY/VIDEO

I, _____ hereby consent to photographs of me being taken 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 pre-operative and post-operative 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 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, other Doctors and/or Allied Health care providers involved in the provision of healthcare, and the storing of reports provided to this Practice by other Doctors or 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.
I consent to Dr Simon Zilko's Practice communicating with me via the above provided email address, phone numbers and/or mailing address, including receiving confidential clinical correspondence. I give permission for Dr Simon Zilko or his staff to contact me by email, SMS, mail and/or telephone, and if necessary leave a message.

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

REFERRAL SOURCE

How did you hear about Dr Simon Zilko? *Referred by:* ☐ GP ☐ Specialist ☐ Physio ☐ Podiatrist

☐ Australian Orthopaedic Association website ☐ Royal Australasian 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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Therapy and Rehabilitation: podiatry and physiotherapy may be an important part of your treatment. For privately insured patients, often your extras insurance will cover a portion of these fees, but there is usually a gap.

Orthotic Devices & Splints: many operations performed by Dr Zilko require the use of a walking boot, post-operative surgical shoe and/or splint. Dr Zilko will determine the type of device required for your operation, and will usually supply and fit it pre-operatively. The costs for orthotic devices/splints are:

- Surgical shoe - $50
- VACOcast boot - $250 *(Health fund extras provides ~40-80% back)*
- VACOped Achilles boot - $385 *(Health fund extras provides ~40-80% back)*
- VACOtalus brace - $150 *(Health fund extras provides ~40-80% back)*
- Even-up shoe raise - $35
- Bunion Sleeve - $38
- Budin Toe Splint - $12-15

Depending on your level of extras cover, you will usually receive 40-80% back on the cost of the boots/braces. Please note that boots/braces purchased independently are usually not eligible for any health fund rebates as they are not an orthotic device prescribed by Dr Zilko, and second-hand boots are strictly not allowed due to infection control risks. If you require a plaster to be applied in the post-operative period, an orthotist or physiotherapist will do this and they usually charge a fee. *A complete list of available products with pricing is available in the rooms and on request.*

Medical Imaging: you may require X-rays, ultrasounds, CT or MRI scans, injections or other imaging techniques. The radiology clinics can provide you with details of the costs, but most imaging services will generate a gap. You may wish to call different radiology companies to obtain costs for any tests Dr Zilko orders. During some operations, especially for total ankle joint replacements, X-rays are taken intra-operatively and you may be charged a gap by the radiology company.

Forms & Reports: Dr Zilko is happy to assist you with the completion of insurance and other forms if requested, though a fee for this service is payable upfront. The fee varies depending on the complexity of the documentation and the time taken to complete it. A quote can be provided.

WorkCover / Insurance Commission of Western Australia / Veterans' Affairs

Dr Zilko accepts payment from these organisations for your treatment, including clinic and surgical fees. The same should apply to hospital fees and the fees of other health providers, although you should check this with individual providers if in doubt. The costs of X-rays, other medical imaging, and orthotic devices, splints and dressings are normally fully covered.

If you have an approved workers compensation or motor vehicle claim then your medical expenses should be fully covered, but in the event that your insurer refuses to pay any of Dr Zilko's fees, then ultimately they are your responsibility.

I CONFIRM THAT I HAVE READ AND ACCEPT THIS FINANCIAL CONSENT:

Patient Name: _____ Signature: _____

Date: ____/____/_____ *Information accurate as at 1 August 2022.*

Please Note: If we enlist the services of a debt collector to recover unpaid fees, a 13.2% surcharge will be applicable to cover the debt collectors' costs.

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MEDICAL QUESTIONNAIRE – Private & Confidential

Please answer these questions fully or discuss them with Dr Zilko. Information about your medical history is for Dr Zilko only, and is important in planning any treatment.

Occupation: _____ Shoes for work (eg steel caps): _____

Have you ever had **surgery on your foot or ankle**? ☐ Yes ☐ No

If so, please list operations, date of surgery and surgeon: _____

_____

Where have you had X-rays, CT, MRI, ultrasound, injections or other imaging of your foot/ankle?

☐ SKG ☐ Perth Rad Clinic ☐ Western Rad ☐ Capital Rad ☐ Envision ☐ My Radiology
☐ I-Med ☐ Prime Radiology ☐ HIS – Defence ☐ Apex (Global) ☐ Healthcare Imaging Services
☐ Canning Vale Rad ☐ Great Southern Rad ☐ Geraldton Rad Other: _____

Have you ever had any of the following **medical conditions**:

Diabetes: ☐ Type 1 ☐ Type 2
Management: ☐ Diet only ☐ Tablets ☐ Insulin
Last HbA1c %: _____ *Date:* _____

Inflammatory arthritis:
- ☐ Rheumatoid arthritis
- ☐ Ankylosing spondylitis
- ☐ Psoriatic arthritis
- ☐ Other : _____

Pain issues:
- ☐ Chronic pain
- ☐ Complex regional pain syndrome (CRPS)
- ☐ Fibromyalgia

Mental health:
- ☐ Anxiety
- ☐ Depression
- ☐ Other mental health issue: _____

Blood clots:
- ☐ Deep Vein Thrombosis Year/s: _____
- ☐ Pulmonary Embolus Year/s: _____

- ☐ Osteoporosis/osteopaenia (↓bone density)
- ☐ Heart attack
- ☐ Heart disease
- ☐ Stroke (CVA/TIA)
- ☐ Neurological condition: _____

- ☐ Lung disease (eg sleep apnoea, asthma, COPD)
- ☐ Liver disease/failure
- ☐ Hepatitis B ☐ Hepatitis C ☐ HIV
- ☐ Cancer – type & treatment: _____

Other major medical conditions:
_____
_____

Are you on any **blood thinning medications**?

☐ Aspirin ☐ Warfarin (Coumadin) ☐ Clopidogrel (Plavix)
☐ Rivaroxaban (Xarelto) ☐ Apixaban (Eliquis) ☐ Clexane/Heparin injections
Other: _____

Do you take any **immune-suppressing drugs**, such as steroids or rheumatoid drugs?

If so, please list medications & doses: _____

Do you **smoke**? ☐ Yes ☐ No

Cigarettes – average # per day: _____
Other: _____

Do you **drink alcohol**? ☐ Yes ☐ No

Average drinks/day: _____
History of alcohol abuse: _____

Patient Name: _____ Signature: _____ Date: ____/____/_____