DR SIMON ZILKO
ORTHOPAEDIC FOOT + ANKLE SURGEON

PATIENT REGISTRATION

PERSONAL DETAILS

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

First Name: ________________________________ **Surname:** ________________________________

Address: ____

Suburb: ____ **Postcode:** _________________

Email: ____

Occupation: ____

Telephone Numbers:

Mobile: ______________________ Home: _____________________ Work: ____________________

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

Name: ____ Date of Birth: _____/______/________

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

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

Contact number: _______________________ Relationship to you: __________________________

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: ____

PLEASE TURN OVERLEAF

Dr Simon Zilko ABN 35 192 898 398
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3 Barry Marshall Pde,
Murdoch WA 6150

Hollywood Medical Centre
Suite 37, Level 1,
85 Monash Ave,
Nedlands WA 6009

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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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