DR MATTHEW FREE
Orthopaedic Surgeon | Knee Specialist

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*PLEASE ANSWER ALL SECTIONS. ALL INFORMATION COLLECTED IS CONFIDENTIAL.*

| SURNAME | GIVEN NAMES | PREFERRED NAME | GENDER |
|---|---|---|---|
| | | | |

| HOME ADDRESS | POSTAL ADDRESS (IF DIFFERENT FROM HOME ADDRESS) |
|---|---|
| | |

| MOBILE NO. | TELEPHONE – HOME | EMAIL ADDRESS |
|---|---|---|
| | | |

| DATE OF BIRTH | AGE | OCCUPTION | ABORIGINAL & TORRES STRAIT ISLANDER |
|---|---|---|---|
| | | | ☐ YES ☐ NO |

**INSURANCE STATUS**

☐ UNINSURED ☐ PRIVATELY INSURED ☐ DVA ☐ TAC OR WORKERS COMPENSATION

| MEDICARE NUMBER | REFERENCE No. | EXPIRY | VETERANS AFFAIRS No. | CARD COLOUR |
|---|---|---|---|---|
| | | | | |

**HEALTH FUND INSURER**
FUND NAME: MEMBERSHIP No.: MEMBER >12 MONTHS: YES / NO

**REFERRING DOCTOR**
NAME: PRACTICE:

**FAMILY DOCTOR (IF NOT REFERRING DOCTOR)**
NAME: PRACTICE:

**EMERGENCY CONTACT**
NAME: RELATIONSHIP: PHONE No:

**WORKCOVER ONLY** ACCEPTED CLAIM YES / NO

CLAIM NO.: .....

EMPLOYER: .....

INSURER: .....

CLAIMS OFFICER NAME (IF AVAILABLE): .....

**TAC ONLY** ACCEPTED CLAIM YES / NO

CLAIM NO.: .....

DATE OF INJURY: .....

PLACE OF INJURY: .....

**MEDICAL HISTORY** – PLEASE ANSWER ALL QUESTIONS

HAVE YOU EVERY HAD ANY OF THE FOLLOWING?

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| HIGH BLOOD PRESSURE | ☐ | ☐ | KIDNEY DISEASE | ☐ | ☐ | CANCER | ☐ | ☐ |
| HEART CONDITION | ☐ | ☐ | LUNG DISEASE | ☐ | ☐ | EPILEPSY | ☐ | ☐ |
| PACEMAKER | ☐ | ☐ | ASTHMA | ☐ | ☐ | HEPATITIS | ☐ | ☐ |
| DIABETES | ☐ | ☐ | BLOOD CLOT | ☐ | ☐ | | | |

DETAILS OF OEPRATIONS IN THE PAST .....

DO YOU HAVE ANY ALLERGIES? .....

DO YOU TAKE ANY BLOOD THINNING MEDICATION? .....

LIST OF CURRENT MEDICATIONS .....

ARE YOU PREGNANT? .....

DO YOU SMOKE? NO YES HOW MANY PER DAY? .....

**PATIENTS PLEASE NOTE**
If surgery is recommended, please note that Dr Free charges a gap. Our team will provide you with full details prior to booking your procedure. It is your responsibility to confirm your level of cover with your insurer. Payment is required at least seven days prior to your scheduled surgery.

Additional costs may be incurred from other providers involved in your care, such as the anaesthetist or surgical assistant. Depending on your private health insurance, you may also be required to pay a hospital excess upon admission. Please check with your health fund regarding any excess or co-payment obligations. Medications, pathology, and radiology services related to your treatment may incur additional out-of-pocket expenses.

I understand the above information and acknowledge that it is my responsibility to confirm with my health insurance fund the level of cover that I have and any costs they charge. I consent to the collection and use of my personal and medical information for the purposes of my treatment and in accordance with privacy laws. I authorise release of relevant medical information to other healthcare providers involved in my care.

Name ..... Signature .....

Date .....