DR MICHAEL MCAULIFFE

ORTHOPAEDIC SURGEON

Knee, hip and lower limb specialist

PATIENT DETAILS

TITLE: MR MRS MS MISS MASTER OTHER

SURNAME:

GIVEN NAMES:

ADDRESS:

TELEPHONE NO: (H) (W) (M)

EMAIL ADDRESS:

DATE OF BIRTH:

PRIVATE HEALTH FUND AND CARD NUMBER:

MEDICARE NUMBER AND EXPIRY DATE:

USUAL GP: (IF DIFFERENT FROM REFERRAL)

If this is a workers' compensation claim, please fill in the details in the section below:

WORKERS' COMPENSATION ORGANISATION:

WORKERS' COMPENSATION CLAIM NUMBER:

WORKERS' COMPENSATION CONTACT PERSON:

If parent or guardian of above patient, please complete the section below:

TITLE: (PLEASE CIRCLE) MR MRS MS MISS MASTER OTHER

SURNAME:

GIVEN NAMES:

I consent to the above information being used for some or all of the following purposes by Dr McAuliffe and/or his secretary:

- Creating an account for consultations, operations, reports.
- Booking operations and/or treatments.
- Referrals to other doctors, for pathology, radiology, etc.
- This practice is interested in providing quality services for patients. In order to provide these services information may be collected for entry onto a **secure** website for quality assurance/research purposes with access not available to members of the public.

A copy of our privacy policy is available for your perusal.

Signature (Patient or Guardian)

Date