DR JOHN TAWFIK

Dr John Tawfik | MBBS, B Pharm, FRACS (Ortho), FAOrthA | Hand and Wrist Surgeon
Phone 1300 TAWFIK (1300 829 345) | **Fax** 02 8079 0679 | **Email** info@tawfik.com.au
Correspondence: St Luke's Clinic, Hornsley House, 20 Roslyn Street, Potts Point 2011
Potts Point - Sydney CBD - Wollongong | Provider no. 237704QY | ABN 50 803 920 320
tawfik.com.au

PERSONAL DETAILS:

Mr/Mrs/Ms/Miss/Dr, Surname:_____ First Name:_____

Preferred Name:_____ Date Of Birth: ____/____/____ Email: _____

Residential Address:_____

Suburb: _____ State: _____Post Code:_____

Postal Address (if different):_____

Mobile:_____ Home Phone:_____ Work Phone: _____

Occupation:_____ Hobbies/sports: _____

Injured Hand: R/L ? Dominant Hand: R / L ?

Emergency Contact:_____ Phone:_____ Relationship to Patient: _____

Referring Doctor:_____ Phone:_____ Fax:_____

Clinic:_____

Address:_____

Local GP (if different):_____ Phone:_____ Fax:_____
Clinic:_____

Address:_____

Other Hand/ Orthopaedic Surgeons seen: _____

_____

HEALTH DETAILS:

Medical Conditions, e.g.: ◊ Diabetes ◊ Kidney Disease ◊ Heart Disease
◊ Asthma ◊ Blood Pressure ◊ Lung Disease
◊ Hepatitis ◊ Epilepsy ◊ Other: _____

Current Medications: _____

Allergies: _____

Previous Operations: _____

Have you been in hospital in the last three (3) months? YES NO

_____

THE ACCOUNT IS TO BE PAID BY:

☐ SELF – Continue Page 1
☐ INSURANCE CO)
☐ SOLICITOR) → **Continue over page**
☐ EMPLOYER)

Private Health Fund: _____ Membership No.: _____

Are you covered for hospital? YES NO Are you covered for Physiotherapy? YES NO

Medicare No.: _____ Position No. on card: _____ Expiry date: _____

Signature: _____ Date: _____

NAME: _____

WORKER'S COMPENSATION OR THIRD PARTY DETAILS:

Employer at time of injury: _____

Employer Address: _____

Employer Phone: _____ Contact Person: _____

Occupation: _____

Job Description: _____

I am aware, that if my account is <u>not</u> paid by the insurance company, I am liable for payment of the fees.

Signature: _____ **Date:** _____

Insurance Company: _____

Insurer Address: _____

Claim Number: _____

Date Of Injury: _____ How did the injury occur? _____

_____

Claim Officer/Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Solicitor: _____

Solicitor Address: _____

Phone: _____ Fax: _____ Email: _____

I give permission for reports to be provided to the third party responsible for the payment of all doctors' accounts and other parties involved in my treatment/management.

I agree that I am seeing Dr Tawfik for consultation and treatment and not for the purposes of seeking a medicolegal report.

Signature: _____ Date: _____

<u>PLEASE NOTE:</u> If the above information regarding who will be paying for your consultation/ operation accounts is not supplied, **you will be responsible for payment**.