Associate Professor Justin Roe - Patient Registration Form

Patient's Title:

Given Name(s):

Surname:

Date of Birth:

Phone: **(M)** **(H)** **(W)**

Email:

Street Address:

Suburb: **Post Code:**

Postal/Billing Address (If Different):

Parent's Name (if child):

Next of Kin: **Phone:** **Relationship:**

Fees paid by: ☐ **SELF** ☐ **WORKERS COMP** ☐ **VETERANS AFFAIRS** ☐ **OTHER:**

Family Doctor:

Doctors Address:

Referring Doctor:

Address:

Physiotherapist or Physio Clinic:

Address:

Your Occupation:

Private Health Fund: **Number:** **Ref**

Medicare No: **Ref Number:** **Exp:**

Medicare Acct Holder (if patient is child): **DOB:**

Dept Veteran Affairs No: **Exp:**

Has another Orthopaedic opinion been sought? ☐YES ☐NO

Permission to Collect and Store Information:

☐ I have read the above and agree to the collection and storage of information. I authorize Dr/Prof Roe to release medical information to the Referring Doctor/ Insurance Company/ Solicitor or the other persons nominated by me.

SIGNED: Print your name **DATE:** Click to enter a date.

Once complete, please return these forms to admin@justinroe.com.au or print and bring with you to your appointment

Associate Professor Justin Roe Knee Injury Assessment Form

YOUR FULL NAME:

YOUR DATE OF BIRTH:

1. Date of Consultation:

2. Which is your affected knee ☐Left ☐Right

3. How long has your knee been bothering you?

4. If applicable, what were you doing when you injured your knee?

5. What is the main problem with your knee?

5a. Please tick any knee symptoms that have been experienced in the last month:

☐ swelling	☐ pain	☐ grinding
☐ instability/giving way	☐ catching	☐ difficulty squatting
☐ locking	☐ difficulty upstairs	☐ locking joint
☐ difficulty downstairs	☐ stiffness	

6. What treatment have you had for your knee injury?

7. Are your symptoms: ☐ improving ☐ worsening ☐unchanged

8. Have you injured the knee previously, or had surgery to either knee (please describe)?

9. What activities do you wish to return to following your treatment

10. What are your expectations from today's consultation with Dr Roe?

11. Please enter your height: weight:

Associate Professor Justin Roe Workers Compensation Details

Workers Compensation (only complete if applicable)

Date of Injury:

Claim Number:

Insurance Company:

Insurance Company Address:

Case Manager:

Case Manager Phone No:

Case Manager Fax No:

Name of Employer:

Employer's Address:

Employer's Phone Number:

I have provided the above information to the best of my knowledge and understand that I will be personally responsible for the payment of all Medical Fees should the cost not be met by my insurer.

NAME: **DOB:**

SIGNED: **DATE:**