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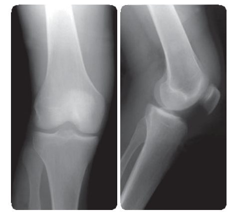
Christos M. Kondogiannis

MBBS FRACS
Orthopaedic Surgeon



Mercy Private

Welcome. Please fill in this form to help us provide you with the best possible treatment. This information will be kept confidential to protect your privacy.

Title: Mr/Mrs/Ms/Miss/Master First Name: ____________________ Surname: ____________________

Address: ____

Suburb: ____________________ Postcode: ____________________

Phone: Home: ____________Mobile: Email:

Date of Birth: ____________ Current Age: ____________ Occupation: ____________

Next of Kin: ____________ Relationship: ____________ Phone: ____________

Person Responsible For Fees: Self / Parent / TAC / WorkCover / Veteran's Affairs / Other

Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ ( ) ref no.

Do you have a Private Health Insurance: Yes / No **Health Fund Name:** ____________________

Health Fund Membership No: ____________________ Date Joined: ____________

Reason for consultation: Left / Right ____

Referring Doctor: ____

Name & Address of Family Doctor (if different): ____

Do you have an Aged Pension or Health Care Card?: No / Yes Card No.: ____________

Veteran's Affairs Number: ____________________Colour of DVA Card: ____________

If TAC or WorkCover: Claim No.: ____________________Date of Accident / Injury: ____________

Insurance Company: ____

Employer: ____

Employer Address: ____

Employer Phone: ____________________Contact Person: ____________________

Medical History

Previous Hospitalisation: Yes / No **Allergies**: ____

Pre-existing medical conditions: (eg. Heart Disease / High Blood Pressure / Lung Disease / Asthma / Diabetes / Blood Clots / Bleeding Disorder / Stomach Ulcers / Other)

No / Yes: Details: ____

Regular Medications: ____

Do you smoke? No / Yes If yes, how many? ____

Notice about fees:

The cost of a consultation is above the Medicare schedule fee. This means you will not recover the full fee after claiming from Medicare. Accounts are payable at the time of consultation. There may be additional charges for further procedures eg. Injections / plasters.
TAC, WorkCover, DVA and other compensable accounts will be sent according to details provided. If there are no details, the account will become the responsibility of the patient. Please note: If your account requires debt collectors, you will be responsible for their extra charges.

I have read the above, and agree to abide by the payment terms of this practice:

SIGNATURE: ____ Date: ____________

Thank You

The Park Clinic
Specialised Orthopaedics