Sydney Shoulder Unit™

DR Sushil Pant
BMedSc(Hons) MBBS(Hons) FRACS (Orth) FAOrthoA
Orthopaedic Shoulder Surgeon

Suite 211 Edgecliff Centre,
203-233 New South Head Road,
Edgecliff NSW 2027
sydneyshoulderunit.com.au

All correspondence to:
PO Box 170 Edgecliff NSW 2027
P: 02 9215 6100 F: 029215 6190
E: admin@drpant.com.au

Title: Given Name: Surname:

Date of Birth:

Home address:

Suburb: Post Code:

Home phone: Work: Mobile:

Email: Occupation:

Next of Kin/ Emergency contact : Phone:

Medicare No: Ref No: (next to name): Expiry:

Private Insurance Fund: Membership Number:

Hospital Cover: Yes ☐ No ☐ Covered for Physiotherapy : Yes ☐ No ☐

DVA: WorkCover/ CTP: Yes ☐ No ☐ (please see below)

Referring Doctor: Clinic:

Usual GP (if different) : Clinic:

Usual Physiotherapist: Clinic:

Are you taking any medications that thin the blood: Yes ☐ No ☐ if so, please list:

List of all medications being taken:

Medical History:

Other:

Allergies: (Please Specify)

CONSENT FORM - For the office of Sydney Shoulder Unit. Under the care of Dr Sushil Pant, Orthopaedic Surgeon.
We request your consent to collect personal information for the primary purpose of providing quality health care. I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the health care and treatment provided. I consent to the handling of my information by this practice for the purpose set out above.

Signature: Date:

For patients under Work Cover or CTP please complete the relevant fields on the following page.

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Worker's Compensation or Third Party Details:

Title: Given Name: Surname:

Date of Birth:

Claim Number: Insurance Company: Injury Date:

Employer at time of injury:

Employer Address:

Employer Phone: Contact Person:

Occupation:

How did the injury occur? (briefly outline):

Case Manager/ Claim Officer: Phone : Fax:

Email:

Solicitor: Phone: Fax:

Email:

Solicitor Address:

My account is to be paid by: ☐ Self ☐ Insurance Company ☐ Solicitor ☐ Employer

Please note: If the above information regarding who will be paying for your consultation/ operation accounts is not supplied, you will be responsible for payment.
I am aware, that if my account is not paid by the above, I am liable for payment of the fees.

Signature: Date:

CONSENT FORM - 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 Sushil Pant for consultation and treatment and not for the purposes of seeking a medicolegal report.

Signature: Date: