TINTENBAR
MEDICAL CENTRE

Patient Registration Form: Work related Injury

Patient Details:	
Title (Mr/Mrs/Dr etc):	Date of Birth:
First Name	Surname:
Occupation	
Telephone (home):	Mobile No:
Email:	
Home Address:	
	Post code:
Postal Address:	
	Post code:
Date of last Tetanus Injection	Allergies
Next Of Kin:	
Title (Mr/Mrs/Dr etc):	Surname:
First Name	Telephone (home):
Relationship:	Mobile No:
Address:	
	Post code:
Do you authorise your Next of Kin to access your health care records? Yes / No	
Emergency Contact: (If this is different to N.O.K please provide details)	
Title (Mr/Mrs/Dr etc):	Surname:
First Name(s):	Telephone (home):
Relationship:	Mobile No:
Employer Details:	
Company Name:	Position:
Contact Person:	Telephone:
Email:	
Address:	
	Post code:
Accident and Insurance:	
Date of Injury:	Nature of Injury:
Is this visit a Workers Compensation Yes/No	A Motor Vehicle Related Injury Yes/No
Other type of accident (eg. Sporting) Yes/No	
If yes, please provide details:	
Claim No:	Insurance Company:
Payment Details:	
Employer (Workers Compensation) ☐	Insurer (Motor Vehicle accident related) ☐
Insurer (other type of accident) ☐	Self (Private) ☐
If yes, Please provide further details:	

I agree that expenses, cost or disbursements incurred by Tintenbar Medical Centre in recovering any outstanding monies (including debt collection fees, agency fees, solicitors costs, court fees and business searches) or taking or defending any legal action arising in any way from this agreement shall be paid by myself should the worker compensation claim be denied. **I accept responsibility of payment of all charges for services rendered should my workers compensation claim be declined and understand the consultation cost may not be covered by Medicare. If required I consent to Tintenbar Medical Centre to contact my employer in relation to my work injury only.**

Signature:	Date:
Clinic Staff:	Date: