

PATIENT INFORMATION SHEET



PATIENT'S SURNAME: _____ GIVEN NAME: _____ TITLE: _____

DATE OF BIRTH: _____ HOME PHONE: _____

WORK PHONE: _____ MOBILE PHONE: _____

Which number would you prefer us to call you on regarding results and appointments? _____

HOME ADDRESS: _____ POSTCODE: _____

PATIENT EMAIL ADDRESS: _____

NAME OF PARENT OR GUARDIAN IF MINOR: _____

ADDRESS IF DIFFERENT TO ABOVE: _____ POSTCODE: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

NEXT OF KIN PHONE: _____

GP NAME: _____

GP PRACTICE NAME & ADDRESS: _____

MEDICARE NO: _____ **EXPIRY DATE:** _____

MEDICARE REF NO: _____ (small no. in front of patient's name on card)

DVA / PENSION / HEALTH CARE CARD: YES NO **TYPE:** _____

CARD NUMBER: _____ **EXPIRY DATE:** _____

HEALTH INSURANCE: YES NO **FUND NAME:** _____

MEMBER NO: _____

Have you served out your waiting period with the fund to make you eligible for hospital claims? YES NO

Do you have cardiac exclusions on your cover? YES NO

I authorise the release of my medical records from existing and past health care providers to Dr Rolf Gomes for my current care and future treatment.

DATE: _____ **SIGNATURE:** _____

PRIVACY NOTE: This information is required to enable us to accurately maintain our records and to ensure that patients are correctly billed. The authorisation will allow us to access your previous medical records for information needed to assist with your assessment and treatment. Phone numbers will be used to confirm appointments. If you have any concerns regarding this, please discuss them with the receptionist or with Dr Gomes during your consultation.