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PATIENT INFORMATION FORM

Patient Name: Title: ___ Given Name: ______________ Surname: __________________

Gender (please circle): Male / Female **Date of Birth:** ____/____/____

Ethnicity: ☐ Aboriginal ☐ Torres Strait Islander ☐ Caucasian ☐ Other: ____________

Wheelchair Access Required: ☐ Yes ☐ No

Contact Details

Phone: Home: ________________ Work: ________________ Mobile: ________________

Preferred Contact Number: ☐ Home ☐ Work ☐ Mobile

Email: ____

Residential Address: ____

Postal/Billing Address (if different from above)**:** ____

Occupation: ______________________________ Job Title: ______________________________

Medicare Number: ________________________ Reference: ___ Expiry: ____/____

Department of Veteran Affairs

Card Number: ________________________ Card Type (please circle)**:** Gold / Silver / White

Pension Pension Type: __________________________ Pension Number: __________________

Private Health Health Fund: ______________________ Member Number: _________________

GP Details

GP Name: ____

Practice Name and Address: ______________________________________

Emergency Contact Person OR Parent/Guardian (if patient is a minor)

Name: ______________________________ Relationship to Patient: __________________

Home: __________________ Work: __________________ Mobile: ______________________

PRIVACY STATEMENT

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

Date: ____/____/____ **Signature:** ____________________________________

Privacy Notes: 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 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 treating doctor during your consultation.