



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 **First Name:** _____ **Surname:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Phone: Home: _____ Work: _____ Mobile: _____

Date of Birth: _____ **Current Age:** _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

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

Do you have a Private Health Insurance: Yes / No

Health Fund Name: _____ **Date Joined:** _____

Health Fund Membership No: _____ **Medicare No:** () no. left of name

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