



**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:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Next of Kin:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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

**Medicare No:**  ( ) no. left of name

**Do you have a Private Health Insurance:** Yes / No **Health Fund Name:** \_\_\_\_\_

**Health Fund Membership No:** \_\_\_\_\_ **Date Joined:** \_\_\_\_\_

**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**