

Dear Patient

Appointment Date :

Please complete the details below in full and return to us by mail, fax or email prior to your appointment. Please bring any x-rays you may have with you on the day of your appointment.

Title: Mr/Mrs/Ms/Miss/Dr First Name: _____ Surname: _____

Address: _____ Postcode: _____

Phone: (H) _____ (W) _____ (Mob) _____

Date of Birth: _____ E-mail: _____

Occupation: _____

Name & Address of your usual doctor: _____

Name and telephone no. of next of kin: _____

Person responsible for fees: SELF/ TAC/ WORKCOVER / VETERANS AFFAIRS / PARENT

If parent, name of parent responsible for account _____

Medicare No: _____ Ref No. on card _____ Exp: _____

Pension Card No: _____ Veterans Affairs Card No: _____

Do you have Private Health Insurance YES / NO

Health Fund Name: _____ Member No: _____

If TAC or WORKCOVER :-

Insurance Company: _____

Claim No. _____ Date of Accident : _____

Employer's Name & Address _____

Employer Phone: _____ Contact Person: _____

Do you have any medical problems : Diabetes Asthma High Blood pressure Heart disorder Other

If other please provide brief details: _____

Regular medications: _____

Allergies to medication: _____

FEE NOTICE

A standard consultation is \$125.00 and review \$70.

TAC, Workcover and DVA accounts will be sent directly to the relevant agency.

I have read the above and agree to abide by the payment terms of this practice. I consent to all or any of the above information to be released to other health providers and agencies during the course of my treatment.

Signature: _____ Date: _____

**Mr. R. Dallalana, Level 7, 166 Gipps Street, East Melbourne 3002, Tel: 8415 1907, Fax: 8415 0132,
Email dallar@theparkclinic.com.au (Please note we are at Gipps Street East Melbourne and not Gipps Street Collingwood)
and also at 255 Moreland Road, Brunswick. For all enquiries please telephone 8415 1907**