PATIENT INFORMATION FORM

Today's Date _____

Please note that full payment is required on the day of your initial and any subsequent consultations.

As Medicare does not completely cover the cost of your consultation, the gap payment becomes your responsibility.

PERSONAL DETAILS

Title: _____ Family Name: _____Given Names:_____

Date of Birth: _____ Country of Birth _____ Gender: _____

Marital Status: _____

If the patient is under 16 year of age- Parent's Full name:_____

DOB of parent : _____ Medicare No of parent: _____

Postal Address: _____State: _____ Postcode: _____

Email Address: _____

Would you like to receive correspondence regarding your surgery via email? _____

(Your information will not be shared for any advertising and marketing purposes)

Our practice uses "My Health Record" to obtain information that is required to support your care (eg Shared Health Summary from your GP including previous health concerns, medications and allergies) and routinely adds information including specialist letters relating to your care. Please talk to us if you wish to understand more. **I consent to information being obtained and uploaded to My Health Record. Yes ☐ No ☐**

Telephone (home) _____ Business/mobile_____

Would you like to receive SMS appointment reminders?_____ (This will not be used for marketing purposes)

Occupation: _____ Are you of Aboriginal or Torres Strait Islander origin? Yes ☐ No ☐

Referring doctor:_____

Name of your GP and clinic name/Location :_____

Next of Kin: _____ Relationship _____Telephone_____

How did you hear about us: Word of mouth ☐, Google/Internet ☐, My doctor ☐, Other:_____

MEDICARE / HEALTH FUND DETAILS

Medicare Number: _ _ _ _ _ _ _ _ _ _ Ref No: ___ (The number next to your name)

Do you have Private Hospital cover? Yes ☐ No ☐

If yes, Name of fund:_____ Membership No: _____

DEPARTMENT OF VETERANS AFFAIRS (IF APPLICABLE)

Department of Veteran's Affairs Card Number: _____ ☐ Gold card ☐ White Card

DECLARATION I _____

Certify that to the best of my knowledge and belief, the particulars set out on this form are correct. I am aware of the conditions relating to the payment of my account. I agree to my personal information being included in Central Day Surgery quality assurance and clinical audit activities .

Patient or Guardian's Signature:_____ Date: _____