PATIENT INFORMATION SHEET

Mr Sam Joseph

Private & Confidential

Dr/Mr/Mrs/Ms/Mst/Miss…… D.O.B……
(Given Name) **(Surname)**

Address…… Postcode……

Phone (H)…… (W)…….. (M)……

Email Address ……Occupation ……

Next of Kin ……Relationship……Contact No……

Referring Doctor's Name ……

GP's Name ……

GP's Address……

……

Medicare No: __ __ __ __ __ __ __ __ __ __ __ Card Ref No: ___ Expiry: ___ / 20____
(next to name)

Health Fund……Membership Number……

Dept. of Veteran Affairs No…… DVA Card Colour……

Is this a possible TAC/Workcover claim? YES / NO If YES: Please see our staff.

GENERAL HEALTH: Height:…… Weight:……

Allergies? ……

History of: Heart Attack: YES / NO Stroke: YES / NO

Significant Medical History including active problems: ……

……

Have you or an immediate family member ever had a BLOOD CLOT or DVT? YES / NO

If YES, please provide details: ……

……

Medications? ……

……

Do you take blood thinners? YES / NO If YES, please provide details: ……

……

Your consent is required:

PRIVACY POLICY: I have read and understand the requirements outlined in the Privacy Policy of this medical practice as detailed overleaf, and give my consent for my information to be used in this manner.
FEES FOR PROVISION OF SERVICES: I have read and understand the Fees For Provision Of Services listed overleaf. I understand that unless otherwise stated there is no Medicare or health fund rebate for these fees.
FINANCIAL CONSENT: I understand that there are expenses associated with private practice medical and surgical care that are not fully rebatable by Medicare or health funds.

Patient Signature…… **Date**……