Title: *Mr / Mrs / Ms / Miss / Mstr / Dr (please circle)* Date of Birth: ................................. Given Names: ............................................................. Surname: ........................................

# Contact Details

Address: ..........................................................................................................................................

Suburb:......................................................................... Postcode:........................................

Phone: (h)....................................... (m)........................................... (w)......................................

Email: ..............................................................................................................................................

|  |  |  |
| --- | --- | --- |
| Next of kin |  |  |

Name:........................................................................... Relationship:...................................

Phone: (h)....................................... (m)........................................... (w)......................................

# Insurance

Medicare Number: Ref # (next to name): ………… Exp Date: …../…..

Private Health Fund: .................................................... Membership #: ..........................................

HCC/Pension #:............................................................. DVA #:........................... Type: ................

# Treating Doctors

Family Doctor (GP): ...................................................... Suburb: ...........................................

Referring Doctor:.......................................................... Suburb: ...........................................

Other Specialists:.......................................................... Suburb: ...........................................

This practice complies with the Privacy Act 1988, including the way we collect, store, use and disclose health information. Personal information obtained from you in our consultation may be used to provide information to your referring and other medical practitioners and allied health professionals.

# **I HEREBY CONSENT TO MY PERSONAL INFORMATION BEING RELEASED BY DR FELICITY ADAMS OR ANY OTHER MEDICAL PRACTITIONER AND ALLIED HEALTH PROFESSIONS AS AND WHEN REQUIRED.**

# **PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**