PATIENT INFORMATION SHEET

Please complete the following questionnaire.
This information will be entered into our patient database and only used in accordance with our Privacy Policy.

PATIENT DETAILS

Title: Miss Ms Mrs Dr Other ______

First Name: ____________________

Surname: ____________________

Previous Name: ____________________

DOB: ____/____/________

Medicare No: [| | |] [| | | |] [ ]

Prefix [ ] Expiry Date: ____/____

DVA No: (if applicable) ____________________

Indigenous Status: Aboriginal Torres Strait Islander
(Please circle) Aboriginal & TSI Neither

PATIENT ADDRESS & CONTACT DETAILS

Street: ____________________

Suburb: ____________________

State: ________ **Postcode:** ________

Phone (h): ( )

Phone (w): ( )

Mobile: ____________________

Preferred Contact Number: ____________________

FAX: ( )

Email: ____________________

PARTNER/CONTACT PERSON

Name: ____________________

Relationship: ____________________

DOB (partner): ____/____/________

Street: ____________________

Suburb: ____________________

State: ________ **Postcode:** ________

Phone (h): ( )

Phone (w): ( )

Mobile: ____________________

PATIENT HEALTH FUND DETAILS

Private Health Fund: **YES** [ ] **NO** [ ]

Fund Name: ____________________

Fund No: ____________________

Member Name: ____________________

Obstetric/Gynaecology cover: **YES** [ ] **NO** [ ]

DEFENCE PERSONNEL ONLY

PM Keys No: ____________________

Referral No: ____________________

PATIENT'S REFERRAL DETAILS

Referring Dr: ____________________

Location: ____________________

Phone No: ( )

Referral Date: ____/____/________

Office Use Only
Referral Valid: 3 Mths [ ] or 12mths [ ]

GP (if different): ____________________

Location: ____________________

Phone No: ( )

Please feel free to provide any further information.

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Note: *If you require any surgical procedure in the rooms such as amniocentesis etc, would you like to have someone with you at the time of the procedure?*

YES [ ] **NO** [ ]

I agree to pay all accounts within the practice's specified time period In the event of a late payment, the practice reserves the right to charge a late fee.

Signature: ____________________ Date: ____________