PATIENT INFORMATION SHEET

Title: _______ First Name: __________________ Surname: __________________________

KNOWN AS : ______________________________

Address: ____

Suburb: ______________________________ Postcode: __________________________

Date of Birth: _______________/_______/________

Home Phone: ______________________________ Work Phone:_________________________

Mobile No: ______________________________ SMS Reminder: YES / NO

Email: ____

Medicare No:______________________________ Ref:_________ Expiry: _____/_________

Private Health Fund:_____________________ Membership No:__________________________

Do you have Top Hospital Cover? YES / NO (please circle)

Have you had Private Insurance for more than 1 year? YES / NO

Health Card/Pension No:__________________ EXPIRY ______/______/______________

DVA Card No: ____

Referring Doctor: ____

Usual GP Name: (if different from above) ____

GP Address: ____

Next of Kin Name:________________________________Phone: __________________________

Allergies: ____

CONSENT

The Privacy Act 1988 requires that medical practitioners obtain consent from each patient with regards to the collection, disclosure and access of personal information.

PLEASE READ LAMINATED NOTICE BELOW

I consent to BMI collecting, using and disclosing my personal information as outlined and I understand that:

- I am entitled to access my own heatlh records except where access may be denied as outlined overleaf.
- I may withdraw my consent except when legal obligations must be met.

By signing this form I also give permission for personal information to be handed to a third party should I default on payment of my account

Signed:__________________________________ Date:__________________________________