PATIENT DETAILS

PLEASE CIRCLE ONE **Mr/Mrs/Miss/Ms**

Given Names:..... **Known As:** .....

FAMILY NAME: .....

ADDRESS: .....

DATE OF BIRTH: ..... **NAME OF FAMILY DOCTOR:** .....

PHONE NUMBERS: **HOME:** .....

WORK: ..... **MOBILE:** .....

MEDICARE CARD NUMBER:..... **Expiry Date:** .....

MEDICARE CARD REF NO: ..... **(Number in front of patient's name)**

DVA NUMBER: ..... **(Veterans' Affairs Patients Only)**

ARE YOU COVERED FOR TREATMENT IN A PRIVATE HOSPITAL **YES/NO**

IF YES PLEASE COMPLETE THE SECTION BELOW.

NAME OF PRIVATE HEALTH FUND: .....

MEMBERSHIP NO: .....

(Please show all your cards to the Secretary)

I, ...give my authorisation for medical information in regard to myself to be released to Dr P Ainsworth. I also give my consent for him to release medical information in regard to myself to my referring practitioner, other treating doctors and hospitals where I have been treated. I understand that my Health Fund may request access to my medical file. Our Privacy Policy is available for review upon request.
I also give Dr Ainsworth permission to supply clinical information to the relevant interested parties (eg Next Of Kin) below:

NAME	RELATIONSHIP TO YOU
.....	(.....)
....	(.....)
.....	(.....)

PATIENT'S SIGNATURE ..... **DATE:**.....