CONFIDENTIAL
PATIENT INFORMATION
(Please Print)

Mr / Mrs / Ms / Miss / Master / Dr (please circle)

Name: (Surname) ..... (Given) .....

Sex: Male / Female Date of Birth .....

Postal Address: ..... Residential Address (if different)

....

.....P/Code .... P/Code .....

Home Phone No ..... Work Phone No .....

Mobile Phone No ..... (agree to SMS appointment reminders being sent)

E-mail address .....

If under the age of 18, Parent's name .....

Emergency contact Name ..... Phone .....

Referred by:…….. GP ..... ……

Physio/Podiatrist:..... Other providers:.....

Medicare No _ _ _ _ _ _ _ _ _ _ Valid to ...../..... Ref No (eg. 1) .....

Vet Aff. No ..... Occupation.....

Do you have private health insurance? Yes / No (please circle)

Fund Name ..... Member No .....

Coverage type: ..... Hospital / Extras Only (please circle)

I have been a member for over 12 months? Yes / No

MEDICATIONS (Please list).....

.....

.....

ALLERGIES (Please list) .....

.....

<u>Workers Compensation / Third Party</u> (If applicable)

Insurance Company ..... **Claim no.** .....

Employer..... **Case Manager** .....

AUTHORITY – PLEASE READ

I agree for Dr Pankaj Rao to be my treating specialist and give permission to be examined with regard to the condition for which I have been referred. I hereby give my consent for medical information concerning myself or my child to be supplied to my referring Doctor / Employer / Insurance Company / Solicitor or any other parties as requested. **I also accept that in the event of any dispute then the account rendered becomes the responsibility of the patient or parent / guardian if the patient is under 18 years of age. I certifiy that the information provided on this form, to the best of my knowledge, to be true and correct.**

....

Signature of Patient / Parent / Guardian Date