

## Patient Details

Title

Surname:

Given Name:

Sex: Male / Female

Date of Birth:

/ /

Postal Address:

Residential Address: (If different)

Home Phone No:

Work Phone No:

Mobile Phone No:

(Agree to SMS appointment reminders being sent)

Email Address:

If under the age of 18, parent's name:

Emergency Contact Name:

Phone:

## Medical Information

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?

Fund Name:

Member No:

Coverage Type:

Hospital / Extras Only

I have been a member for over 12 months?

Medications: (Please List)

Allergies: (Please List)

### Workers Compensation / Third Party: (If applicable)

Insurance Company:

Claim No:

Employer:

Case Manager:

**Thank you. Our staff will be in contact soon with your appointment date and time.**

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### 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 certify that the information provided on this form, to the best of my knowledge, to be true and correct.

Signature of Patient / Parent / Guardian

Date

### Form Notice

To submit the completed Patient Information Consent Form save this file to your device and attach the completed document to an email and send to: [reception@rao.net.au](mailto:reception@rao.net.au).