Southern Cardiology NSW

INITIAL CONSULTATION PATIENT INFORMATION

FIRST NAME……..MR/MRS/MS ……

SURNAME……DATE OF BIRTH……

ADDRESS……..

SUBURB…….. ….. POST CODE……

TELEPHONE (HOME)…… (WORK)…… (MOBILE)……..

MEDICARE NUMBER _ _ _ _ _ _ _ _ _ _ (10 numbers)

NUMBER NEXT TO YOUR NAME ON MEDICARE CARD …… EXP DATE……

PRIVATE HEALTH FUND: YES ☐ NO ☐

NAME OF FUND…… MEMBER NO: ……..

PENSION NUMBER BLUE CARD: ……

HEALTH CARE CARD……

SENIORS HEALTH CARE CARD……..

VETERANS AFFAIRS NX……

GP'S NAME & ADDRESS……..

NEXT OF KIN: (MR/MRS/MS)……

PHONE/MOBILE…… RELATIONSHIP……..

PREFERRED METHOD FOR RECEIVING CONFIRMATION / REMINDERS FOR APPTS:
☐ PHONE CALL (24 HRS PRIOR)
☐ SMS TEXT MSG (48 HRS PRIOR)

ALL PATIENTS TO READ AND SIGN BELOW PLEASE

I hereby give authority for my medical records to be forwarded and received to/by medical practitioners and allied health professionals, in relation to my medical condition.

Sign:……Date ……..