DR GRAEME WALKER
GYNAECOLOGIST & COLPOSCOPIST

PATIENT INFORMATION AND PRIVACY CONSENT FORM

TITLE: ☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR SEX: ☐ M ☐ F

SURNAME: ______________________________

FIRST NAME: ______________________ DATE OF BIRTH: ______________

PHONE: (H) ______________ (W) ______________ (M) ______________

ADDRESS: ______________________________

______________________________ POST CODE: ______________

EMAIL ADDRESS: ______________________________

MEDICARE NO: ______________ REF #: ______ EXPIRY DATE: ______________

DO YOU HAVE PRIVATE HEALTH INSURANCE: ☐ YES ☐ NO

HEALTH FUND: ______________ MEMBERSHIP NO: ______________

VETERAN AFFAIRS: ______________ PENSION NO: ______________

NEXT OF KIN: ______________________________

RELATIONSHIP: ______________________ PHONE: ______________

USUAL GP: ______________________________

PRIVACY ACT

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN IF YOU AGREE.

I give permission for the release of my medical records to assist with the assessment, treatment and management of my medical condition. I also give permission for information to be requested from any medical practitioner, health professional or organisation to assist with my medical treatment as required.

SIGNED: ______________________ DATE: ______________

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