DR GEOFF TRUEMAN
PATIENT DETAILS AND CONSENT FORM

Title:________Surname:_________________________Given Name_______________________

Address:____

Suburb:____Postcode____________________

Email Address____

Date Of Birth :__________________________Home Phone:_____________________________

Work Phone:___________________________Mobile Phone:_____________________________

Medicare No________________________Ref No___________Expiry Date_______________

Private Health Fund____________________________Member No______________________

Do You Have Hospital Cover? YES / NO Have you been in fund for 12 months YES / NO

Department of Veteran Affairs No (if applicable)_____________________________________

Referring Doctor____

Usual GP:____

Next Of Kin_______________________________________Phone No______________________

CONSENT: Your consent is required for this Practice to collect information from you and conduct medical examinations, including diagnostic imaging, for the primary purpose of providing quality health care to yourself. We also require your consent to disclose information to others involved in your health care management, this includes treating doctors and specialists outside this practice, as well as any medical tests or reports that are relevant to your ongoing treatment.

We send an SMS message to confirm your appointments – are you willing for us to use your mobile phone number for this purpose? YES / NO

FINANCIAL POLICY: Any procedures and examinations conducted in this Practice may incur an additional fee which is the responsibility of the patient.

I, _________________________consent to the handling of my information by this Practice for the above purpose and any additional charges incurred relating to the services provided.

How will you be paying for the account today? CASH CHEQUE CREDIT CARD EFTPOS

PATIENT/GUARDIAN____________________________________DATE____________________