ATTENDING PATIENT(S) DETAILS

PLEASE ONLY FILL IN THE DETAILS OF THE PATIENT(S) BEING SEEN – NOT OTHER ATTENDING FAMILY MEMBERS

TITLE	FIRST NAME(S) AS ON MEDICARE CARD	LAST NAME	DATE OF BIRTH	MEDICARE CARD REFERENCE # (number next to patient's name)	TICK IF PRIMARY CONTACT

MEDICARE CARD NUMBER: __ __ __ __ __ __ __ __ __ __ **EXPIRY DATE:** _____ /_____

FOR CHILD PATIENTS ONLY – PLEASE NOMINATE ONE PARENT/GUARDIAN TO BE THE ACCOUNT HOLDER FOR MEDICARE ONLINE CLAIMING (WHEN THE PATIENT IS UNDER 18 YEARS OF AGE).

TITLE: **NAME IN FULL:** **D.O.B:**_____ /_____ /______ **REFERENCE #**______

RELATIONSHIP TO PATIENT:

MEDICARE NUMBER (if different to above): __ __ __ __ __ __ __ __ __ __ **EXPIRY DATE:** _____ /_____ **REFERENCE #**______

PRIMARY CONTACT DETAILS

MOBILE: **HOME NUMBER:** **EMAIL:**

FULL RESIDENTIAL ADDRESS (MANDATORY FIELD FOR MEDICARE ONLINE CLAIMING) – NO PO BOX

STREET: **STATE:**

SUBURB: **POST CODE:**

GOVERNMENT HEALTH CARE CARD/PENSION CARD/SENIORS CARD – CENTRELINK – PLEASE SHOW RECEPTION

☐ **PENSION CARD** ☐ **HEALTH CARE CARD** ☐ **COMMONWEALTH SENIORS CARD**

NAME	PATIENT CUSTOMER REF NUMBER (CRN)	EXPIRY DATE

ADMINISTRATION ONLY: CENTRELINK CARD(S) SHOWN TO RECEPTION ☐ INITIALS:

DEPARTMENT OF VETERANS AFFAIRS (DVA) - GOLD CARD ONLY - PLEASE SHOW RECEPTION

CARD NUMBER:____

ADMINISTRATION ONLY: DVA CARD SHOWN TO RECEPTION ☐ INITIALS:

PLEASE TURN OVER →

FOR ADULT PATIENTS ONLY – PLEASE NOMINATE AN EMERGENCY CONTACT BELOW

NAME: **RELATIONSHIP TO PATIENT:**

PHONE NUMBER: **EMAIL:**

FOR CHILD PATIENTS ONLY – PLEASE NOMINATE ALL AUTHORISED PARENTS/GAURDIANS BELOW

All parents and/guardians are to be listed here who are allowed to call us, make bookings and have access to patient's file.

IF BELOW IS LEFT BLANK, DETAILS WILL ONLY BE GIVEN TO THE ADULT WHO SIGNS THIS FORM.

FULL NAME	RELATIONSHIP TO PATIENT	CONTACT NUMBER	EMAIL ADDRESS

CONSENT – TO BE SIGNED BY PATIENT / PARENT / GUARDIAN WHO IS 18 YEARS OR OLDER

I UNDERSTAND AND CONSENT THAT (READ THOROUGHLY)

- Investigations may include skin testing, which can rarely cause severe reaction (1:30 000), which our practice is equipped to manage.

- The consultation letter will ONLY be sent to the referring doctor within 2 weeks time.

- If I require a copy to be sent to any other doctor than my referring doctor I need to ask the allergist in the consultation.

- If I have any follow up questions after my consultation with the allergist, I am to see my referring doctor / my general practitioner.

- If I require an attendance of an appointment letter for school or work, I need to ask the reception for this at the time of the appointment.

- The full consultation fee is to be paid on the day of my consultation (without a referral no Medicare rebate will be issued and testing will be billed).

- Centrelink card (HCC/Pension) rates only apply if a **valid** Centrelink card is shown to reception on the day of my consultation.

I ____consent to the disclosure to medical/specialist practitioners/allied health practitioners and institutions that may require information about my medical history, but only to the extent necessary to access/treat the particular condition that I have consulted the specialist practitioner about.

SIGNED: ____ **DATE:** ____________