DR FISHER PATIENT INFORMATION FORM

Title..... First Name..... Surname.....

Middle Name.....Preferred name.....

Postal Address.....

Residential Address.....

DOB.....

Contact Numbers: Home..... Work..... Mobile.....

Email Address.....

Medicare No..... Position on card ..... Expiry Date.....

Are you fully covered to be treated in a Private Hospital? Yes/No

Fund Name..... Membership Number.....

Dept of Veterans' Affairs No..... DVA card colour.....

Name of Referring Doctor.....Name of Usual GP.....

Marital Status: □ Married □ De Facto □ Single □ Separated □ Divorced □ Widowed □ Same sex partner

Occupation.....

Spokesperson/Next of Kin.....

Relationship (to you)..... Phone .....

The Spokesperson/Next of Kin can collect medical information on my behalf? YES / NO (please circle)

Do you have any allergies? Yes/No .....

From time to time Dr Fisher and staff may need to consult with other medical professional providers. This will be done by either telephone, written referral, secure electronic transmission or facsimile. I hereby consent for Dr Fisher and staff to discuss/share my medical history/diagnosis with the necessary service providers.

YES / NO (please circle)

Signature..... Date.....