WELLVIEW CONSULTING ROOMS

Name: (Dr/Mr/Mrs/Miss/Ms) –

First name_____ **Surname**_____

Address:_____

_____ **Postcode:**_____

Date of Birth_____ **Email Address**_____

Telephone ***(please circle preferred no. to confirm appts)***

Home_____ **Mobile**_____ **Work**_____

Marital status: ***(Please circle)*** **Single Married Widowed Divorced Defacto Separated**

Medicare No:_____ **Exp. Date:**_____ **Ref. No:**_____

DVA (Veterans Affairs) No:_____ **Type of Card (circle) - Gold or White**

Insurance/Worker's – Compensation/Solicitor's Details *(if applicable)*

Name of Company _____

Address_____

Claim No:_____ **Phone No:**_____

Contact Person:_____

Referring Doctor:_____

Phone No:_____ **Provider No:**_____

Usual GP (if different from above) _____ **Phone No:**_____

Details of usual Pharmacy – Name_____ **Phone No:**_____

Emergency Contact – Name_____ **Phone No:**_____

How did you find out about our practice? ***(Please circle)*** **GP Family/Friend Internet Other**

Can we leave message to confirm appointment **Yes** ☐ **No** ☐

Can we confirm appointments with family members **Yes** ☐ **No** ☐

Cancellations with less than 24 hours notice may incur a cancellation fee.
Please ask for your prescriptions during your appointment – scripts outside of appointments will be subject to a $A30 fee.

This Practice is committed to comply with the *Privacy Act 1988* and all amendments to the Act, including the *National Privacy Principles (NPPs).* The Practice will ensure respect for consumer privacy in handling all patient information. All reasonable steps will be taken to comply with the *NPPs.*