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COAST Gastroenterology

FIRST NAME: _____ *SURNAME:* _____

MIDDLE NAME: _____ *KNOWN AS:* _____

ADDRESS: _____

SUBURB: _____ *STATE:* _____ *POST CODE:* _____

DOB: _____

HOME PHONE: _____ *WORK PHONE:* _____

MOBILE: _____

EMAIL: _____

MEDICARE NUMBER: __ __ __ __ __ __ __ __ __ __ *REF:* __ *(BESIDE YOUR NAME)* *EXPIRY DATE:* __ __ / __ __

PRIVATE HEALTH FUND: _____ *MEMBERSHIP NUMBER:* _____ *REF#*_____

DVA NUMBER: _____ ☐ *GOLD* ☐ *WHITE*

NEXT OF KIN: _____

RELATIONSHIP TO YOU: _____ *(PARTNER, WIFE, HUSBAND ETC)*

PHONE NUMBER: _____

REFERRING DOCTOR: _____

NAME OF CLINIC/LOCATION: _____

USUAL GP: (If different from above) _____

NAME OF CLINIC/LOCATION: _____

PLEASE READ CAREFULLY:

This form contains personal and sensitive information about you. This information is collected by this practice for the provision of the best health care for you. This information may be used for your health care, any insurance claim or other matter relating to your health care. This information may be disclosed to other health service providers, a statutory health authority, insurers, debt collectors or other health practitioners. In order to provide the highest quality health care, it may be necessary to obtain further health and/or personal history from other health providers.

Please note this is a ***Private Billing Clinic*** *and therefore we* ***Do Not Offer Bulk Billing.***
Medicare rebates are only applicable to patients with a current Medicare card and a current referral letter.

By signing this form, you acknowledge that payment is required at the time of the consultation, and you give consent to the collection, use and storage of information herein.

SIGN: _____ *DATE:* _____