Vascular Care Centre Patient Information Sheet

PERSONAL DETAILS:

Title: Mr / Miss / Mrs / Ms / Dr

Full Name (including middle name) : _____

Date of Birth: __ __ / __ __ / __ __ Gender: Male / Female / Prefer not to disclose

Weight: _____ KG Height: _____ CM

Postal address:

_____

Home Ph: __ __ __ __ __ __ __ __ Work Ph: __ __ __ __ __ __ __ __

Mobile Ph: __ __ __ __ __ __ __ __ __ __ Email: _____

Emergency contact Name and Number: _____

Relationship to you: _____

MEDICARE DETAILS:

Medicare Card Number: __ __ __ __ __ __ __ __ __ __ Ref No: __ Expiry Date: __ __ / __ __

HEALTH FUND:

ARE YOU IN A PRIVATE HEALTH FUND: YES / NO

Health Fund name: _____ Membership Number: _____

Does this Practice have Permission to contact your Health Fund on your behalf? Yes / No

VETERANS AFFAIRS: (for Gold/ White card holders only)

Card number: _____ Colour: _____

PENSION DETAILS: Is this an: Aged Pension ☐ OR Healthcare Card ☐

Card Number: _____ Expiry Date: __ __ / __ __ / __ __ __

Regular GP and Practice : _____

Other treating specialists: _____

How did you hear about us? _____

By signing below you are consenting to the collection and disclosure of your personal and Medical information. This information may be used for administration and training, accreditation, quality assurance activities and legal purposes. Your information may be used while liaising with other treating doctors/specialists, Medicare and health funds. De-identified medical information may also be collected for research purposes.

SIGNED:_____ **DATE**: __ __ / __ __ / __ __ __ __