DATE: ___/ ___/ ___

DR C S WALLER

SURNAME………………………..……….. GIVEN NAME(s)……………………………………….Mr/Mrs/Miss/Ms/Dr

Home Phone No ……………………… Mobile………………………………. D.O.B……………. Age ……..

Address ………………………………………………………………………………. Post code……..………..

Health Fund …………………………Fund No……………………….... Occupation……………………………

Medicare No ……………………………………..…..… Repat No ....…………………………….…………..…

Email ………………… ……………………. …………………………………………………………………..

Referring Dr……………….. ………………………………………………………………………………….

Address ………………………………………………………………………………………. Post code…………..

Family Dr (if different & you require copy of this correspondence sent)**…………………………………..…**

Address ……………………………………………………………………………………… Post code …………..

Next Of Kin …………………………………………..…Relationship ………..… Contact No……….……..……

WORKERS COMPENSATION CASES ONLY

Employers Name …………………………………………………………………………………..……......

Address ……………………………………………………………………………………… Post code…………..

Phone ..……………..…..… Fax ..……………… ……. Contact Person…………………...................................

Insurance Co ………………………………………………… Ph …………………….. Fax ……………..…..…

Address …………………………………………………..……………………….… Post code ……….....

Date of Injury …………………….…..... Claim No ……………………..………………………..…………..

I declare that this is an accepted insurance company claim. I understand if the claim is declined I must pay the consultation cost (expected at the time of consultation)

Signed: ……………………………………………………………………………………….

PHYSIOTHERAPY (If you require a copy of your correspondence to se sent to a physiotherapist)

Name ……………………………..…………………………... . Ph …………………… Fax …………….…….

Address ……………………………………………………………….............................. Post code ……………

ALL PATIENTS TO SIGN: **Permission is given to collect and release information on my medical history in order to provide appropriate healthcare. In addition I understand certain information may be used for medical research and audit purposes. I understand that it is my responsibility to pay my account at the time of consultation. I undertake to pay any additional expenses incurred in recovering overdue fees.**

Signed: …………………………………………………………………………………………...