DR WARREN KENNEDY
PATIENT INFORMATION SHEET

Surname: _____ Miss/Mrs/Ms/Mr/Dr

Given Names: _____ DOB: _____

Address: _____

_____

Phone: _____ Mobile: _____

Email: _____ (please print)

☐ Tick this box if agree to Dr Kennedy's newsletter to be emailed to you.

Occupation: _____

Employer: _____

Name of Spouse (if applicable): _____

Contact Person (Emergency): _____ Phone: _____

MEDICARE DETAILS

Number: _____ Expiry Date: _____ / _____

PRIVATE HEALTH INSURANCE

Name of Fund: _____ Member Number: _____

DEPARTMENT OF VET AFFAIRS

Gold Card Number **TX:** _____

HEALTH CARD or PENSION CARD

Card Number: _____ Expiry Date: _____

DR TURNER, WILLIAMS, BLOMFIELD
KENNEDY & BUNTING
18 Elizabeth Street, HOBART TAS
Telephone: 03 62200600 Facsimile: 03 62200688

CONSENT TO COLLECT PATIENT INFORMATION

Medical care requires full knowledge of patient health information by all members of a medical team. To ensure quality and continuity of patient care, a patient's health information has to be shared with other health care providers/diagnostic facilities from time to time. Some information about patients is also provided to Medicare and private health funds if relevant, for billing and medical rebate purposes.

I _____ consent to the above.

Signature _____

Date_____