Dr Sachin Khetan

New Patient Personal Details

CONFIDENTIAL

Surname _____ Ms Mrs Miss Mr Master Dr Other: _____

Given Name(s) _____ M/F

Date of Birth: _____ Nickname / Preferred Name _____

Residential Address _____

Suburb/Town _____ State _____ P/Code

Postal Address _____

Suburb/Town _____ State _____ P/Code ☐☐☐☐

Phone:-Home _____ Work _____ Mobile _____

Email _____ ☐ I consent to receiving text message reminders for my appointment(s)

Medicare No. ☐☐☐☐ ☐☐☐☐☐ ☐ Ref No(in front of name) ☐ Exp Date ☐☐/☐☐

Private Health Fund _____ GOLD / SILVER BRONZE / BASIC Member No _____

Only if Applicable

DVA No. ☐☐☐ ☐☐☐☐☐ GOLD / WHITE Covered Condition(s) _____

ADF Personnel: Service No(PMkeyS) ☐☐☐☐☐☐☐ Reg/Unit _____

Work/Accident Cover _____ Claim No _____

Your Occupation _____

Allergies _____

Regular GP and/or Clinic (if different to referring Dr) _____

Next of Kin / Emergency Contact _____ Phone _____

DISCLOSURE CONSENT:

I _____ (Print Name) Consent to the disclosure to medical/specialist practitioners, allied health practitioners and institutions who may require information about my medical history, but only to the extent necessary to assess/treat the particular condition that I have consulted the Specialist Practitioner about.

I understand I can retract this consent at any time and to do this I must do so in writing.

Signature _____ Patient / Legal Guardian Date _____