Title: First name: Surname:

Preferred name: DOB:

Address:

Suburb: State: Postcode:

Country:

Mobile: Home phone:

Medicare #: ref #:

Private Fund Name: Membership #:

DVA#: Card colour: Pensioner Card #:

Next of kin contact: Mobile:

Relationship:

Referring Dr:
Suburb:

Local GP if different from above
Name:
Suburb:

- I authorise Dr Kalanie to release and access information to/from the referring doctor, my general practitioner, other medical practitioners, health care providers and insurance companies (where applicable) involved in my care.

- I understand the contact details I provide will be used for communication between the practice and myself.

- I authorise the practice to access my health fund and Medicare details on my behalf if required.

- I agree to take responsibility for the payment of my accounts.
  All consultation fees are due in full on day of consultation unless pre-approved under work cover/insurer/ADF consultations

Date: Signed: