DR. RICHARD PARKINSON
NEUROSURGEON

Suite 402 St Vincent's Clinic 438 Victoria Street Darlinghurst 2010

PATIENT INFORMATION FORM

MR. MRS. MS. MISS. MASTER.

SURNAME ……………………………… FIRST NAME ……………………………………..

ADDRESS ……………………………………………………………………………………… ………

…………………………………………………………SUBURB………………………POSTCODE…..

DATE OF BIRTH ………/……../……... PHONE NO. HOME ………………………………..

WORK ………………………………….. MOBILE ………………………………………………..

OCCUPATION ……………………………. EMAIL ADDRESS………………………………………..

REFERRING DOCTOR ……………………………………………………..

GP ADDRESS ………………………………………………………..……………………………….

MEDICARE NO ……………………………………………. EXP …………… NUMBER ON CARD ( )

VETERAN AFFAIRS NO. ……………………………………

PRIVATE HEALTH FUND …………………………………MEMBERSHIP NUMBER………………..

IF WORKERS COMPENSATION OR THIRD PARTY PLEASE COMPLETE THE FOLLOWING DETAILS

DATE OF INJURY ……………………… EMPLOYED BY …………………………………

ADDRESS OF EMPLOYER …………………………………………………………………….

PHONE NO ……………………………... CONTACT (CASE MANAGER)…………………

CLAIM NO ………………………………. INSURANCE CO ………………………………..

ADDRESS OF INSURANCE CO …………………………………………………………………

CASE WORKER ……………………………. PHONE NO ………………………………………..

SHOULD LIABILITY BE DENIED, I UNDERTAKE TO BE RESPONSIBLE FOR ANY OUTSTANDING ACCOUNTS.

PRIVACY ACT:

I , ………………………………………………AGREE TO ALLOW DR RICHARD PARKINSON ACCESS TO ALL RELEVANT INFORMATION REGARDING MY MEDICAL CONDITION. I AGREE THAT DR PARKINSON MAY BE REQUIRED TO FORWARD INFORMATION ABOUT MY MEDICAL CONDITION OR HISTORY TO OTHER HEALTH CARE PROVIDERS OR INSURERS. I UNDERSTAND THAT, TO PROVIDE THE HIGHEST MEDICAL CARE, MY CLINICAL RECORDS MAY BE ACCESSED OR REVIEWED BY STAFF AT THIS PRACTICE.

I ALSO UNDERSTAND THAT THERE MAY BE PHOTOGRAPHIC OR OTHER MEDIA TAKEN FOR A SURGICAL PROCEDURE AS REQUIRED AND I CERTIFY THAT THIS IS ALLOWED TO OCCUR WITH APPROPRIATE CONFIDENTIALITY.

SIGNED……………………………………… DATED…………