NEW PATIENT DETAILS AND CONSENT FORM

Today's date:	Consulting Dr:		
PATIENT INFORMATION			
Title: Dr / Mr / Mrs / Miss / Ms / Prof / Rev			
Name:	Middle:	Surname:	
Date of Birth: / /	Sex: ❑ M ❑ F	Home Phone Number:	Mobile Phone Number:
Street Address:			
PO Box:	Suburb:	State:	Post Code:
Email:			
ACCOUNT DETAILS			
Medicare Card No:	Expiry Date:	Medicare Reference No. Next to your name:	Veterans Affairs Card Number:
Pension Card No:		Pension Card Expiry date:	V/A Card Type: Gold / White
Private Health Fund Name:		Membership Number:	Ref: No
PACEMAKER DETAILS			
Do you have a Pacemaker or Loop Recorder?	Yes / No		
Company *(please circle)*:	Biotronik / Boston Scientific / Medtronic / St Jude Medical / Other……		
IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home Phone Number:	Mobile Phone Number:
Do you give us permission to contact this person in the event of an emergency or if we are unable to contact you? Yes / No			
GP DETAILS – *IF NOT ON REFERRAL*			
GP Name:	Address:	Phone No:	
CONSENT TO SHARE MEDICAL RECORDS: PLEASE TICK ✓ IF CONSENT IS GIVEN:			
❑	I hereby give my consent to allow my medical records from Sydney Heart to be included on My Health Record.		
I hereby give my consent to the release of necessary medical documentation being requested by medical practitioner, hospitals, departments or ancillary practices, such as pathology, radiology etc. I also consent to Sydney Heart obtaining relevant medical information pertaining to my care from such practices. We comply with the Australian Privacy Act – for further information visit http://www.privacy.gov.au			
Patient/Guardian signature…… *Date:*……..			