PROFESSOR GREG BAIN

PERSONAL DETAILS

DR / MR / MST
MRS / MISS / MS ____

(SURNAME) (GIVEN NAMES)

ADDRESS

____

____ **POST CODE** ____________

DATE OF BIRTH ____

TELEPHONE NO: (Home) ______________________ **(Mobile)** ______________________

(Work)___ ______________ **Email Address**____

Next of Kin ______________________ **Relationship** _____________ **Phone** ____________

FAMILY DOCTOR'S NAME AND ADDRESS ____

____

PERSON RESPONSIBLE IF PATIENT IS A MINOR ________________________ **D.O.B.**____________

MEDICARE NO ______________________________ **REF NO** ____ **EXP** __ / __

AGE PENSION CARD NUMBER _________ ____________ **VET AFFAIRS NO** ____________ COLOUR ______

PRIVATE HEALTH HOSPITAL INSURANCE FUND ____________________**MEMBER NO** ________

IS THIS A WORKERS COMPENSATION CLAIM? YES / NO

If 'yes' please see Reception Staff for an additional form

IS THIS A THIRD PARTY / INSURANCE CLAIM? YES / NO

If 'yes' please see Reception Staff for an additional form

FINANCIAL RESPONSIBILITY

As I am seeking private treatment I acknowledge that payment of accounts is my responsibility and that all accounts must be paid within 30 days or other costs may be incurred through a debt collection agency. Professor Bain charges above the Schedule Fee. (Medicare pays only 75% - 85% of the Schedule Fee.) THERE WILL BE GAP PAYMENTS APPLICABLE ON CONSULTATIONS. FULL PAYMENT OF THE ACCOUNT IS REQUIRED ON DAY OF CONSULTATION. I acknowledge and consent that information I have provided on this form may be provided to a third party for purposes related to my health care.

You can discuss further with Dr Bain the collection and access of private information. A detailed information sheet for collection and disclosure of your private information is also available at your request. Please ask at the reception desk for a copy if required.

SIGNED ____ **DATE** ____________________