DR EVA KRETOWICZ

(PN:0945952Y)

PATIENT INFORMATION SHEET

Patient's full name Ms / Miss / Mrs / Mr	Date of birth
Residential Address	Postal Address
Suburb	Suburb
Postcode	Postcode
Home phone no:	Work phone no:
Mobile no:	Occupation
Your email address:	
PRIVATE HEALTH INSURANCE YES / NO	Fund name:
Waiting period served:	Membership No:
Level of cover (eg Hospital and / or Extras)	
MEDICARE No:	Ref No: Expiry date: /
Next of Kin	
Name:	(Relationship to you)
Address:	
Telephone: H M	
General Practitioner: Dr	
Referring Specialist: Dr	
Name of referring doctors practice:	
Any other notes (if applicable)	

PATIENT CONSENT

I CONSENT TO OTHER MEDICAL PRACTITIONERS, HOSPITALS OR HEALTH SERVICE PROVIDERS TO ASSIST IN ANY CURRENT OR FUTURE TREATMENT THAT RELATE TO THE CONDITION I AM CURRENTLY BEING TREATED FOR AND A REPORT TO BE SENT BY DR EVA KRETOWICZ TO MY REFERRING DOCTOR OR SPECIALIST.
(do not sign if you do not consent)

PATIENT SIGNATURE:____DATE:____/____/____