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Title:_____ First Name:_____Surname:_____

Address:_____

Suburb:_____ State:_____ Post Code:_____

DOB:_____ Email:_____

Phone H/W:_____ Mobile:_____

☐ I **DO NOT** want to receive SMS reminders for my appointment

Next of Kin:_____ Relationship:_____ Phone:_____

Usual Doctor:_____ Usual Doctor's Practice:_____

Medicare Card No:_____ Reference No:____ Expiry Date:_____

Private Heath Insurance: Yes / No Name of Health Fund:_____

Policy No:_____ Type of Cover: Hospital & Extras / Extras Only / Hospital Only

Do you have a DVA card? Yes / No DVA No:_____ Colour of Card:_____

Is this a Work Cover Claim? Yes / No (If yes, please notify reception)

How did you hear about us? GP Word of mouth Social Media Website

Other (please specify)_____

Your Privacy, Our Concern – Consent to use your personal information

Dr Ian Baxter and The Sunshine Coast Medical Weight Loss Centre complies with the Commonwealth Privacy Act and all other state and territory legislative requirements in relation to the management of personal information. We collect information that is necessary for the provision of your health care. Personal information obtained from you in your consultation may be used to provide information to various health services involved in supporting your health care management (e.g. pathology, radiology, hospitals or other specialists).
If the patient lacks capacity to consent, a guardian may sign on their behalf, with additional risk considerations. *Please contact us if this situation arises.*
By signing, you affirm that the provided information is true and correct as of the date of completion. I have read and understood the Privacy Policy and understand my rights and responsibilities.

I hereby consent to my personal information being released as and when required.

Signature
Patient / Guardian / Power of attorney (please circle)

Relation to patient
Guardian / Power of attorney

Date: