EMERALD MEDICAL CENTRE LANE COVE

1/90 LONGUEVILLE RD LANE COVE 2066
PH: 9420 0222, FAX: 9420 0333
emclanecove@gmail.com

Title: ______________

Surname:_____________________________________Given Name ________________________

Address:____

____Postcode:____________

Date of Birth: ________ / _________/___________ Occupation:______________________

Contact Number: Mobile ______________________________________

Work ___________________________________ Home ________________________________

Emergency Contact:

___________________________ _________________________ __________________________
(Name) (Relationship) (Phone)

Are you of Aboriginal ☐Yes **or Torres Strait Islander origin?** ☐Yes **Cultural Background:**_________

How did you find us/hear about us?
☐Google ☐Yellow pages ☐True Local ☐Workmate/friend ☐Walked past
☐Other (please list)____

Medicare Number/DVA ______________________________________Ref No:____ Valid to: ____ /___

- Health Care Card Card Number: ____
  Valid to: _________ / ________
- Pension Card Card Number: ____
  Valid to: _________ / ________

For each consultation, I offer to assign my rights to Medicare benefit payable to the doctors of Emerald Medical Centre Lane Cove who will render the medical service. I am aware of my rights to access my Medicare information from Emerald Medical Centre Lane Cove, which will be made available upon my request with adequate notification time. If the information is not readily available, I understand I will be given an explanation in these circumstances.

X ____________________________________ Date ___/___/____

All information disclosed in this form will be treated as confidential to Emerald Medical Centre Lane