DR PHILIP HALL

MBBS MRMed FRANZCOG FROCG FACRRM

PATIENT DETAILS

SURNAME……. FIRST NAME…….....

DATE OF BIRTH…….....

HOME ADDRESS…….....

…….....

MAILING ADDRESS…….....

CONTACT DETAILS

HOME……..……..…….. WORK……..……...….. MOBILE……..…….....

EMAIL…….....OCCUPATION……

MEDICARE NO…….....REF NO……..…….....EXP DATE…….....

PRIVATE HEALTH FUND…….....……..MEMBERSHIP……..

DVA (Veteran affairs)……..

REFERRING DR……..ADDRESS……...

…….....

HOW DID YOU HEAR ABOUT US

GP…….....FRIEND…….....WEBSITE.....OTHER.....

PARTNER DETAILS

SURNAME……FIRST NAME……..

DATE OF BIRTH……MOBILE …….....

Payment is required at the time of consultation. This practice does not Bulk Bill.

Ultrasound examination:
As part of your consultation/investigations it may be necessary by your doctor to perform a transvaginal ultrasound.
I hereby give my permission for this investigation to be undertaken.

Signature.....……...…….. Date……

Privacy Policy
Our privacy policy is designed to ensure the safety of your personal information. This information will be used by this practice for your health treatment and for administrative purposes. For optimal healthcare, we are often required to share this information with your other health practitioners and for this we need your consent. If you have any concerns regarding our handling of your information, please discuss this with myself or my secretary.

I have read the above information and give my consent:

Signature.....……...…….. Date……