PATIENT DETAILS

Michael L Gordon
MBBS (Hons), FRACS
Ear, Nose, and Throat
Head & Neck Surgeon

PLEASE COMPLETE IN BLOCK LETTERS AND GIVE TO SECRETARY WITH YOUR REFERRAL LETTER

SURNAME
(Mr/Mrs/Miss/Ms/Master/Dr).....

FIRST NAMES.....

ADDRESS.....POSTCODE.....

EMAIL.....

PH.NO: Home.....Work.....Mobile.....

DATE
OF BIRTH.....AGE.....OCCUPATION.....

NEXT OF KIN.....PHONE NO.....

REFERRING DR/SPECIALIST NAME.....Date of referral.....

USUAL GENERAL PRACTITIONER.....
(PLS NOTE: REFERRAL FROM GP LASTS 12 MONTHS & FROM SPECIALIST ONLY 3 MONTHS)

ARE YOU PRESENTLY TAKING OR HAVE RECENTLY TAKEN **ASPIRIN OR WARFARIN**?
□ YES □ NO

PLEASE LIST MEDICATIONS THAT YOU ARE PRESENTLY TAKING: □YES □ NO

.....

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DO YOU HAVE ANY KNOWN ALLERGIES? □YES □ NO

PLEASE LIST .....

PRIVATE HEALTH INSURANCE: □ YES □ NO

NAME OF PRIVATE HEALTH INSURANCE COMPANY.....**No** .....

MEDICARE.....Ref.No. on card.....Expiry date: .....

PENSION NUMBER (HCC/AGED/DISABILITY/SOLE PARENT).....

REPATRIATION NUMBER.....

PAYMENT IS EXPECTED AT THE END OF YOUR CONSULTATION

HOW DO YOU WISH TO PAY? (EFT / CASH / CHEQUE / VISA OR BANK CARD)

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WORKERS COMPENSATION/TRANSPORT ACCIDENT COMMISSION **YES / NO**

EMPLOYERS NAME & ADDRESS
DATE OF ACCIDENT **CLAIM #**