PROFESSOR GREG BAIN

PERSONAL DETAILS

DR / MR / MST
MRS / MISS / MS _____
(SURNAME) **(GIVEN NAMES)**

ADDRESS

_____

_____ **POST CODE** _____

DATE OF BIRTH _____

TELEPHONE NO: (Home) _____ **(Mobile)** _____

(Work)___ _____ **Email Address**_____

Next of Kin _____ **Relationship** _____ **Phone** _____

FAMILY DOCTOR'S NAME AND ADDRESS _____

_____

PERSON RESPONSIBLE IF PATIENT IS A MINOR _____ **D.O.B.**_____

MEDICARE NO _____ **REF NO** ___ **EXP** __ / __

AGE PENSION CARD NUMBER _____ _____ **VET AFFAIRS NO** _____ **COLOUR** _____

PRIVATE HEALTH HOSPITAL INSURANCE FUND _____**MEMBER NO** _____

IS THIS A WORKERS COMPENSATION CLAIM? YES / NO
If 'yes' please see Reception Staff for an additional form

IS THIS A THIRD PARTY / INSURANCE CLAIM? YES / NO
If 'yes' please see Reception Staff for an additional form

FINANCIAL RESPONSIBILITY
As I am seeking private treatment I acknowledge that payment of accounts is my responsibility and that all accounts must be paid within 30 days or other costs may be incurred through a debt collection agency. Professor Bain charges above the Schedule Fee. (Medicare pays only 75% - 85% of the Schedule Fee.) THERE WILL BE GAP PAYMENTS APPLICABLE ON CONSULTATIONS. FULL PAYMENT OF THE ACCOUNT IS REQUIRED ON DAY OF CONSULTATION. I acknowledge and consent that information I have provided on this form may be provided to a third party for purposes related to my health care.

You can discuss further with Dr Bain the collection and access of private information. A detailed information sheet for collection and disclosure of your private information is also available at your request. Please ask at the reception desk for a copy if required.

SIGNED _____ **DATE** _____