Patient Information Form

(please bring with you a signed copy)

dr.kate

1.Your Details

Surname: .....

First Name: .....

Preferred Name: .....

Date of Birth: .....

Address: .....

..... Postcode .....

Mobile: .....

Email: .....

Medicare Number .....

Expiry Date: .....

Emergency Contact: .....

Emergency Mobile: .....

How did you hear about us?

.....

I understand that notes, results, radiographs (xrays) and other models relating to my treatment may need to be sent to other medical practitioners to assist in my treatment and I consent to this.

I give my permission for the practice to use the above details to send me appointment reminders via SMS text message

This practice submits data to various disease specific registers (cervical, breast, bowel screening etc) to assist in preventative health. I give my permission for this practice to send on my behalf

I authorise Dr Kate Norris to forward and receive medical reports via fax or electronically (encrypted) on my behalf, if required.

....

Patient's Signature Date

Level 22, Suite 2201, Westfield Tower 2, Bondi Junction NSW 2022
Ph: 02 8095 6423 | drkate@drkatenorris.com.au | www.drkate.com.au

2.About Your Health

Current health concerns:

Goals you hope to achieve from seeing Dr Kate:

Past medical history:

Medications:

Allergies:

Family History:

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