GLASS STREET MEDICAL CLINIC
105 Glass Street, Essendon, VIC, 3040

PHONE: (03) 93792242
FAX: (03) 9351 0951

PAYER'S DETAILS

MR. MRS. MS. MST. MISS
SURNAME:……

FIRST NAME:……..……..

DATE BIRTH:……..……..

TELEPHONE NO:……MOBILE:……

ADDRESS:……

…….POSTCODE:…….

MEDICARE NO:……..REF NO:……EXPIRY:…..……...

PENSION ❑ VETERANS' AFFAIR ❑ HEALTHCARE ❑

CARD NO…….……..EXPIRY:…….....

PRIVATE HEALTH INSURANCE: YES NO

BASIC HOSPITAL ❑ INTERMEDIATE ❑ TOP HOSPITAL ❑

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
I am aware of my right to access the information collected about me, except in some circumstances where the access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
I understand that if my information is to be used for any other purpose other than set out above. My further consent will be obtained.
I consent to the handling of my information by this practice for the purpose set out above, subject to the limitations on access or disclosure that I notify this practice of.

Signed: _____

Date: _____

Witness: _____