Patient Acquaintance Form

Dr Stuart Myers - MyHand.com.au

◯ Mr ◯ Mrs ◯ Ms ◯ Master ◯ Miss ◯ Dr ◯ Prof

Worker's Compensation & Third Party

Family Name:

First Name:

Address

Suburb State NSW PCode

Date of Birth

Home Phone

Work Phone

Mobile

Email

Medicare Number

Ref # Expiry

Health Fund:

Member Number:

DVA #

Ref Dr:

Usual GP:

Insurance Company

Claim Number

Address

Suburb State NSW PCode

Case Manager

Telephone

Employer

Employer

Date of Injury

Permission is given to release the Medical History to the Family Doctor, Insurance Company or Solicitor (where applicable).

All details given on this information Sheet will be kept in strictest confidence. Doctor may use some of your details for the purpose of audit/or medical research.

Please indicate your consent to the above signing this form:

Signature: _____ Date:

Consent for Photographs

I, Name

give my consent to Dr Myers to take photographs if required, prior to, during and after surgery for the purpose of my medical records.

I give permission for these photographs to be used for teaching and educational purposes.

I give permission for these photographs to be shown to other patients.

I understand that I will not be identified in these photographs.

Signature _____

Print Form Submit by Email