St Vincent's Clinic

Dr Mark J. Winder
M.B.B.S. (Hons), M.S., F.R.A.C.S.
Neurosurgeon & Spinal Surgeon
Provider No: 243406AY

NEW PATIENT DETAILS

Mr/Mrs/Ms/Miss _____ First Name _____

Date Of Birth _____Surname _____

Address _____

Postcode _____ Home/Mobile No. _____

Email _____

Medicare No. _____Ref _____ Expires _____

Health Fund _____ Fund No. _____

Pension No. _____ DVA No. _____

Referring Doctor _____

GP (if different to referring doctor) _____

GP Address _____

GP Contact No./Email _____

FOR WORKERS COMPENSATION:

Insurer _____ Claim No. _____

Address _____

Case Manager_____ Contact No. _____

Consent to collect patient information:
1. This practice conforms to the current Federal Privacy Legislation.
2. I consent to the collection and storage of personal and medical information deemed necessary for my treatment. I consent to the release of my medical details to my family and/or referring doctor.
3. I accept all responsibility for the payment of my accounts. In the event that the account is not paid within a period of 3 months, I acknowledge that the practice has the right to release my account information to a debt collection agency and/or credit reporting agency. I hereby consent to pay all legal costs associated with collection of payments.

Signature _____ Date _____