



## MediConnect Consulting Suites

### Personal Information

(Dr/Mr/Mrs/Ms/Miss) Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Country of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ref No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

DVA \_\_\_\_\_ Workcover \_\_\_\_\_

Health Fund: \_\_\_\_\_ Member No: \_\_\_\_\_

### General Practitioners Details

Usual General Practitioner: \_\_\_\_\_

Surgery Address: \_\_\_\_\_

Other Treating Doctors: \_\_\_\_\_

Surgery Address: \_\_\_\_\_

### Medical History:

Drug Allergies: \_\_\_\_\_

Regular Medications: \_\_\_\_\_

I hereby accept responsibility for payment of my account. I give permission for MediConnect Consulting to collect information and if necessary to share information with other Health Practitioners in order to provide optimum treatment.

*"By signing you also consent to the use of Heidi AI for the purposes of secure note and letter generation during consultations. Please discuss with your doctor if you have any questions."*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ALL INFORMATION OBTAINED IS PART OF YOUR PROTECTED MEDICAL RECORD