



MediConnect Consulting Suites

8/259 McCullough St, Sunnybank Q 4109

Personal Information

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

Date of Birth: ____/____/____ Country of Birth: _____

Home Address: _____

Home Phone: _____ Work: _____ Mobile: _____

Email: _____

Medicare Number: _____ Ref No: _____ Expiry Date: _____

For patients under 18, please provide:

Parents Name: _____ Date of Birth: _____

Medicare Number: _____ Ref No: _____ Exp: _____

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.

Signature: _____ Date: _____

ALL INFORMATION OBTAINED IS PART OF YOUR PROTECTED MEDICAL RECORD