Dr Mahi Ranasinghe MBBS, MS, FRACS

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# *PATIENT INFORMATION SHEET*

## *Personal Information*

Dr Mr Mrs Ms Miss Surname:_____ First Name: _____

Date of birth _____/_____/ _____

Address: _____Suburb: _____Postcode: _____

Phone: _____ Email: _____

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No: __ Valid to _____ / _____

DVA No: _____ WorkCover Claim No: _____

Private Health Fund: _____ Membership No: _____

Hospital & Extras cover ◯ Hospital only ◯ Extras only. ◯

Have you been with your health fund for 12 months. Yes / No

## *GP Details*

Name: _____Clinic_____

Address: _____ Suburb_____ Postcode: _____

Phone: _____

## *Current Medications*

| Name | Strength | Dosage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## *Allergies:*

| | | |
|---|---|---|
| | | |
| | | |
| | | |

I hereby accept responsibility of payment of my account. I give permission for Dr Ranasinghe to collect information and if necessary, share my information with other Heath Practitioners in order to provide optimum treatment.

Signature: _____ Date: _____

ALL INFORMATION OBTAINED IS PART OF YOUR PROTECTED MEDICAL RECORDS