

First Name .....

Last Name .....

Number and Street Address.....

Suburb .....Postcode:.....

Mail Address .....

Mobile Telephone .....Home.....

Work Telephone ..... **Please tick preferred contact No**

Birth Date .....

Referring Doctor \* .....

\* (If no referring Doctor, please write name & address of Doctor you will see for your check up in 10-14 days)

Medicare No .....Ref.....Expiry.....

Pension or Concession Card No.....Expiry.....

**Have you ever been treated here before: Yes / No**

**How did you hear about the Gynaecology Centre? (Circle one)**

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**In an emergency please contact:**

Name ..... Telephone.....

**VALUABLES:** Gynaecology Centres Australia take no responsibility whatsoever for valuables or other possessions. Jewellery should NOT be removed. Please arrange safe storage for your other possessions.

**PRIVACY:** Privacy Statement: GCA collects this information regarding your health and relevant social circumstances in order to provide a service to you. Once collected, this information may be sent to the referring doctor. Our secretarial staff, who may also collect additional personal details and type the reports, do so with strict confidentiality. GCA will not disclose your personal information to any other person without your consent.

**COSTS:** Costs are advised before every appointment. Fees are almost always less than recommended by the Australian Medical Association and are payable at the time of consultation.

**I agree to pay all fees at the time of every appointment.**

Signed ..... Date .....