Hawthorn Sports Medicine

25 Linda Crescent, Hawthorn VIC 3122
✆ 03 9819 3499
🖷 03 9819 4599
✉ admin@hawthornsportsmedicine.com.au

Title: Mr / Mrs / Ms/ Miss / Dr (Please circle) Date of Birth: _____/_____/_____

Surname: _____ Given Name/s: _____

Address: _____ Suburb: _____

Post Code: _____ Mobile: _____ Home: _____

Email Address: _____

Emergency Contact Name: _____ Contact Number: _____

Relationship to You: _____

Medicare Card Number: _____ _____ ____ Individual Reference Number: _____ Expiry Date: ____/_____

Health Care Card ☐ Pension Card ☐ DVA Gold Card ☐

Card Number: _____ Expiry Date: _____/_____/_____

Person Responsible for Payment

Self Parent/Guardian DVA (please circle)

Referrer Details

Doctor/Physiotherapist/Chiropractor: _____

Practice Name: _____

Address: _____

Phone number: _____ Email: _____

Medical History (if detailed on GP referral, completion not required).

Do you have any allergies? YES NO **If yes, please detail:**

_____

Do you take any prescription medications? YES NO **If yes, please list:**

_____

Do you take any nutritional or health supplements, e.g., glucosamine and/or fish oil? **If so, please list:**

I hereby consent to any correspondence letters being emailed or faxed to my referring practitioner/s. This includes an emailed copy to me.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature:_____ **Print Name:**_____

Doctors are covered by the Health Privacy Principles as set out in the Health Records Act (Vic) 2001 and the Australian Privacy Principles, as set out in the Privacy Act (Clth) 1998.