DR DANIEL LEWIS
M.B.,B.S.,(Hons)F.R.A.C.P
RHEUMATOLOGIST
CONSULTANT PHYSICIAN

CONFIDENTIAL INFORMATION

Please complete details in block letters

SURNAME: MR / MRS / MS / MISS / MASTER..

GIVEN NAMES ....

ADDRESS ....SUBURB .... POST CODE ....

DAYTIME TELEPHONE NO: .... AFTER HOURS NO. ....

EMAIL ADDRESS:..

WOULD YOU LIKE TO RECEIVE OUR HEALTH INFORMATION EMAIL NEWSLETTER YES / NO

DATE OF BIRTH: ..../............/............ AGE: ....

OCCUPATION: ....

REFERRING DOCTOR'S NAME:...

PERSON RESPONSIBLE FOR ACCOUNT: ....
(Payment is requested on day of consultation)

N.B. A full fee will be payable for cancellations of less than 48 hours notice or non attendances

DO YOU HAVE PRIVATE HOSPITAL COVER? IF SO, WHICH FUND? ....

MEDICARE NO. .... VETERANS' AFFAIRS NO. ....

IF MOTOR ACCIDENT CLAIM NO. .... DATE OF ACCIDENT........../......../........

IF WORKCOVER

EMPLOYER: ....

EMPLOYER'S ADDRESS .... POST CODE ....

DATE OF INJURY ..../......../........

INSURANCE COMPANY.. CLAIM NO. ....

This form authorises Dr. Daniel Lewis to communicate if necessary with other health practitioners regarding your condition

..../......../...........
Signature Date

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