DR. DESMOND SOARES – ORTHOPAEDIC SURGEON

PATIENT INFORMATION FORM:

FIRST NAME: _____ LAST NAME: _____

SEX: MALE FEMALE DATE OF BIRTH : ____/____/____

ADDRESS: _____

_____

STATE _____ POSTCODE: _____

PHONE: (____) _____ MOBILE: _____

EMAIL: _____

SKYPE ID: _____

MEDICARE NO: _____ EXP DATE: ____/____

PRIVATE HEALTH INSURANCE:

FUND NAME: _____ MEMBERSHIP NO: _____

REFERRING DOCTOR: _____

REFERRAL ATTACHED: [ ]

XRAY / US / MRI RESULTS ATTACHED [ ]

Privacy
The information you have provided above will be used to provide you with further services or to answer any requests or enquiries. It is our intention to protect your personal information and to deal with it in a way that is consistent with applicable privacy laws in Australia.

I have read and understand the privacy statement above and the information on Dr Soares website regarding online consultations and wish to proceed with an online consultation.

Signed: _____

Name: _____

Date: _____

PLEASE FILL THIS FORM AND THEN SEND IT TO US BY EITHER OF THE FOLLOWING:

FAX: 07 32087775

EMAIL: loganspecialist@internode.on.net

POST: P.O. BOX 1121, SPRINGWOOD, QLD 4127