Patient Information Form

Patient Name: Miss / Ms / Mrs / Mstr/ Mr / Dr_____
First name Surname

Date of Birth ____/____/____

Street Address: _____

_____
Suburb Postcode

Mobile: _____ **Home:** _____ **Work:** _____

Medicare: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ **Ref:** _____ **Expiry:** _____

DVA (Department of Veteran's Affairs) ___ ___ ___ ___ ___ ___ ___ ___ ___ **Expiry:** _____ **Gold Card / White Card**

Concession Card Number: _____ **Expiry:** _____

Health Fund Name: _____ **Member Number:** _____

Emergency Contact: _____ **Phone:** _____

By providing your email address we are able to give you access to your images online using our Patient Portal.

Would you like access? **YES** **NO**

Email Address: _____

Have you had a Nuclear Medicine Scan TODAY? **YES** **NO**

Patient Consent

I consent to Dr Glenn & Partners Medical Imaging (DGP) using the collected personal health information in accordance with the Privacy Act and DGP's Privacy Policies and I authorise DGP to access my related health information from my referring practitioner. I authorise DGP to dispose of the films from this examination if not collected within 3 months from date of service.
It is DGP policy to ask for full payment on the day of examination. I consent that any outstanding Medicare rebates are transmitted to Medicare, using HIC Online Patient Claiming Function.

Signature of patient (or parent/guardian if under 18)

_____ Date: ____/____/____