Dr Ian Baxter M.B.B.S. F.R.A.C.S.
General and Laparoscopic Surgeon

PROVIDER NUMBER 0572719L

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Title:__________ First Name:________________________Surname:__________________

Address:____

Suburb:____________________ State:________________ Post Code:_________________

DOB:______________________ Email:_______________________________________

Phone H/W:______________________ Mobile:_________________________________

☐ I **DO NOT** want to receive SMS reminders for my appointment

Next of Kin:_________________ Relationship:________________ Phone:______________

Usual Doctor:______________________ Usual Doctor's Practice:______________________

Medicare Card No:_________________ Reference No:____ Expiry Date:________________

Private Heath Insurance: Yes / No   Name of Health Fund:_________________________

Policy No:_________________ Type of Cover: Hospital & Extras / Extras Only / Hospital Only

Do you have a DVA card? Yes / No   DVA No:_________ Colour of Card:______________

Is this a Work Cover Claim? Yes / No (If yes, please notify reception)

How did you hear about us? GP Word of mouth Social Media Website

Other (please specify)____

Your Privacy, Our Concern – Consent to use your personal information

Dr Ian Baxter and The Sunshine Coast Medical Weight Loss Centre complies with the Commonwealth Privacy Act and all other state and territory legislative requirements in relation to the management of personal information. We collect information that is necessary for the provision of your health care. Personal information obtained from you in your consultation may be used to provide information to various health services involved in supporting your health care management (e.g. pathology, radiology, hospitals or other specialists).
If the patient lacks capacity to consent, a guardian may sign on their behalf, with additional risk considerations. *Please contact us if this situation arises.*
By signing, you affirm that the provided information is true and correct as of the date of completion. I have read and understood the Privacy Policy and understand my rights and responsibilities.

I hereby consent to my personal information being released as and when required.

______________________________ ______________________________ ________________

Signature
Patient / Guardian / Power of attorney (please circle)

Relation to patient
Guardian / Power of attorney

Date: