Expirv Date: ----/----/----

Title: Dr Mrs Ms Miss Mr M	Medical Details
First Name:	Referring Dr:
Middle Name:	Suburb:
Last Name:	Regular GP:
Postal Address:	Suburb:
	List medical allergies, if any:
Suburb:	
Post Code:	
	List all prescribed medication:
Date of Divide.	
Date of Birth:/	
Home Phone No:	List all over the counter (non-
Work Phone No:	prescription) medication:
Mobile Phone No:	
Email Address:	
Occupation:	How did you first find out about Dr
Emergency Contact Name:	Khan?
	GP 🗖 Family 🗖 Friend 🗖 Internet 🗖
Relationship:	Please feel free to provide details of
Emergency Contact Phone No:	family/friend if they recommended you:
Medicare Number:	Declaration – to be signed by all patients
	I agree to Dr Arifa Khan accessing all relevant
The number next to your name on your	information regarding my medical conditions. I agree that Dr Khan may be required to forward information
medicare card (the reference No):	about my medical condition or history to other healthcare providers. I understand that in order to
Expiry Date:/	provide the highest medical care, my clinical records may be accessed by relevant staff of this practice:
Health Fund Name: Health Fund No:	Signature: Date://
Ticalari ana ivo.	
Type of Cover Public Hospital: Private Hospital:	Please note this is a private practice and fees are payable at the time of your consultation.
T done Hospital. Tivate Hospital.	These fees are claimable through Medicare; however, as they are above the Medicare rebate,
Veterans Affair No (if applicable):	an out of pocket expense will be incurred.

please discuss this with Dr Khan.