Walker Street DOCTORS

Title	Surname	First Name
Address		
Phone (m)	(h)	(w)
Email		
Date of Birth		Occupation
Country of Birth/Nationality		

Medicare number	Your number on card
Australian Pension number	Expiry
Health Care Card number	Expiry
Veteran Affairs number	Card Type (gold/white)

Name of emergency contact
Relationship
Phone (m) (h) (w)

How did you hear about us? ☐ Friend ☐ Health Professional ☐ Website ☐ Other

Declaration

I authorise Walker Street Doctors to use my personal details to communicate with other health professionals ie pathology, radiology, specialists ☐ Yes ☐ No
I authorise Walker Street Doctors to contact me via sms with appointment reminders ☐ Yes ☐ No
I authorise Walker Street Doctors to contact me via email with results,correspondence, reminders ☐ Yes ☐ No

PAYMENT IS DUE AT TIME OF CONSULTATION , THANK YOU

Signature Date