

PATIENT INFORMATION

PATIENT SURNAME:  
PATIENT FIRST NAMES:  
PATIENT - DOB: GENDER: Male Female  
ADDRESS:

POST CODE:

POSTAL ADDRESS:

POST CODE:

HOME TELEPHONE NUMBER:

EMAIL: @

MEDICARE NUMBER:

REFERENCE: EXPIRY DATE:

MOTHER'S FULL NAME:

MOBILE:

MEDICARE REFERENCE NUMBER:

DOB:

FATHER'S FULL NAME:

MOBILE:

MEDICARE REFERENCE NUMBER:

DOB:

PRIVATE HOSPITAL COVER? YES NO FUND NAME:

MEMBERSHIP NO:

HEALTH CARE CARD OR PENSION? YES CARD NUMBER:

EXPIRY DATE:

OTHER CHILDREN SEEN PREVIOUSLY BY DR COOKSEY:

REFERRING DOCTOR:

ADDRESS:

LOCAL GP (if different to above):

ADDRESS:

All consultation fees are to be PAID IN FULL ON THE DAY, HCC/Pension Card holders will receive appropriate concessions.

This practice will collect personal information in order to provide an accurate medical diagnosis and appropriate treatment. This information is confidential and collected with your consent.

Patients who see Dr Cooksey in her private rooms but have surgery performed at The Women's & Children's Hospital as a public patient should be aware that their procedure will be performed by training Registrars, under Dr Cooksey's or an associated Specialist's supervision.

CONSENTS

- I provide my consent for Dr Cooksey to obtain any health information necessary for the accurate diagnosis and treatment of my child's condition.
- If surgery is advised as a result of our consultation with Dr Cooksey, I accept responsibility to find out all aspects of that surgery including risks, alternatives, possible complications and out of pocket expenses incurred before agreeing to any procedures.
- In the event that my account becomes overdue and the practice has to engage the services of a collection agency, I authorise the practice to provide the agency with personal information. I undertake to pay any collection fees incurred.
- Dr Cooksey may take pre-operative and post-operative photographs. These photographs remain property of the practice and may be used for patient information, teaching, medical presentation and/or publications. I provide my consent for these photographs with (please tick one);
  - No conditions
  - The following conditions (i.e. not for other patient information / not for journal publication)
  - Consent declined for taking of photographs

Parent/Guardian Signature

Date



PAEDIATRIC UROLOGIST  
PAEDIATRIC GENERAL SURGEON



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