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F | +61 3 8080 3250
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Title:		**Date of Birth:**
First Name:		**Surname:**
Address:		**Postcode:**
Home Phone:		**Mobile:**
Email:		
Medicare No:	**Ref:**	**Expiry:**
Pension or HCC No:		**DVA:**
Private Health Insurance Fund:		**Insurance Fund No:**
Name of GP:		
Emergency Contact:	**Phone:**	**Relationship:**
Medications:		
Allergies:		

I consent for **Dr Rudd Cardiology** to obtain and share information regarding my medical condition.

I acknowledge that I am personally responsible for the fees resulting from the consultation and procedures for me/above patient.

Signed: Date _____ / _____ / _____