



Joseph (Jo) Schoeman

UROLOGICAL SURGEON

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Patient Details Form

Title:	First name:	Surname:	
Middle name:	Known as:		DOB:
Residential address:			
Suburb:	State:		Post code:
Postal address:			
Suburb:	State:		Post code:
Home ph:	Mobile:	email:	
Medicare no.:	Ref:		Expiry:
Health Fund Name:	Membership no.:		
DVA no.:	Gold	Orange	White : Please alert reception
Pension no.:			Expiry:
Referring Doctor:		Usual GP:	
Other relevant Doctors:			
Emergency contact name:			
Relationship:		Contact no.:	
CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION & CONSENT TO FEES			
I consent to the use and/or disclosure of my personal health information by Dr Joseph Schoeman to other Health Practitioners involved in my medical treatment and health care. I acknowledge that all accounts for consultations are required to be settled the same day.			
Name: _____		Signature: _____	
Relationship to patient: _____		Date: _____	