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Solace Healthcare Pty Ltd is committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate.

Title:	Dr Mrs Ms Miss Mr Other Child(U12): Master					
Surname:						
First name:					Preferred Name:	
Date of Birth:						
Address:						
Phone/Mobile:					Other:	
Email:						
Occupation:						
DVA patient	YES	NO	Medicare Referral (with Care Plan)	YES	NO	
Medicare & Reference Number:						
Private Health Fund	YES	NO	Pension Card Holder	YES	NO	
Private Health Fund						
Medical History:						
Medications:						
Known Allergies:						
Do you...	Smoke?			Drink Alcohol?		
Main reason for your visit:						
Emergency Contact:	Name:					Relationship to you:
	Contact Number:					
GP Contact details:	Practice Name:					
	Contact Number:					
How did you hear about us?	Solace Healthcare Website () Google () Facebook/Instagram () Doctor/GP () Word of Mouth () HCF Insurance () Other Private Health Insurance () Live/Work nearby () Other ()					

Patient Privacy Policy and Consent

The above information is true to the best of my knowledge. I give permission to Solace Healthcare and authorise my insurance benefits to be paid directly to the practitioner. I understand that I am financially responsible for any balance.

Signature: _____ **Date:** _____