

Dr Mugdha Kulkarni

MBBS, FRANZCOG, CU

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PERSONAL INFORMATION:

First Name: _____ Last Name: _____

Known As: _____ DOB: _____

Street Address: _____

Suburb: _____ Postcode: _____ State: _____

Postal Address (if different from residential): _____

Address: _____

Suburb: _____ Postcode: _____ State: _____

CONTACT INFORMATION:

Mobile: _____ Home Phone: _____

Email Address: _____

ACCOUNT INFORMATION:

Health Fund: _____ Membership Number: _____

Level of Cover: Hospital Full Restricted

How long have you been with this Health Fund? _____

Medicare Number: _____ Ref Number: _____

DVA Number: _____

REFERRAL:

Referring Doctor: _____

Address: _____

General Practitioner (if different to referring doctor): _____

Address: _____

Other Interested Parties: _____

Address: _____

EMERGENCY CONTACT DETAILS:

Emergency Contact: _____ Mobile: _____

MEDICATIONS:

Current Medications: _____

Allergies: _____

MEDICAL HISTORY: Current: Height: _____ Weight: _____

Medical Conditions: _____

Previous Surgeries: _____

PRIVACY AND CONSENT:

I understand that Dr Mugdha Kulkarni handles personal information in accordance with federal and state privacy laws. I consent to the handling of my information by this practice for the purpose of providing me with quality healthcare, which includes permitting my medical information to be obtained from any other medical services involved in my care, my medical information to be shared with other treating allied health professionals. I also give permission for my information to be used for associative administrative and billing purposes.

I understand that in order to provide me with the best available treatment and care Dr Mugdha Kulkarni may be required to perform certain non-invasive diagnostic assessments and or procedures. I hereby give consent to Dr Kulkarni at the discretion of the medical practitioner to conduct such examination/investigations and/ or procedures should they be deemed an essential part of my diagnostic assessment and treatment regime.

FEE POLICY:

I acknowledge and understand that there may be out-of-pocket costs for services provided and that it is my responsibility to confirm with Medicare and/or my Private Health Insurer (if any) as to my eligibility and the amount of any reimbursement, and if a procedure is necessary during my consultation, there may be an associated cost in addition to the standard consultation fee.

I consent to fees for a consultation and/or for a procedure. If I need to cancel my appointment, I will provide at least 48 hours' notice. If I fail to notify the clinic or do not attend my appointment, I understand that I will be charged a cancellation fee, which is not eligible for Medicare rebates.

Print Name: _____ Date: _____

Signature: _____

If you are unable to sign, please tick this box acknowledging the above privacy, consent and fee policy statement.
