*Date:*

CLIENT DETAILS:

|  |  |
| --- | --- |
| Title: First Name: Surname: DOB: | |
| Gender / Pronoun: | |
| Email Address: | |
| Residential Address: | |
| Postal Address (if different): | |
| Phone Number (mobile): (home:) (work): | |
| Occupation: | |
| Medicare Card Number : Line# on card: Expiry: | |
| Health Fund Yes/No | |
| If yes, Fund Name: Member Number: | |
| Emergency Contact: | |
| Relationship: |  |
| Phone Number: | |
| Address: | |

I give permission for Dr. Zoe L. Barnett to contact the abovenamed emergency contact in the event she cannot reach me and has concerns regarding my welfare. Further, I also give permission for Dr. Zoe L. Barnett to discuss aspects of my case that she believes may be relevant regarding her concerns for my wellbeing.

Signature: …………………………………..