*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: …………………………………..