



Dr Beth Russ

OBSTETRICIAN & GYNAECOLOGIST
MBBS, FRANZCOG

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Please complete both sides

Title: Mrs [] Ms [] Miss [] Mr [] Dr [] (please tick) Other: _____

Surname: _____ Given Names: _____

Preferred name: _____ Date of Birth: _____

Address: _____

Phone: (h) _____ (w) _____ (m) _____

Email: _____

Occupation: _____ Partner's Occupation: _____

Have you been to this Practice before? _____

Usual GP & Clinic: _____

Interpreter required? Yes [] No [] Language: _____

Medicare No: _____ Ref No: _____ Expiry: _____

Pension/HCC Card No: _____ Expiry: _____

Private Health Fund: _____ Membership No: _____

Covers private hospital? Yes [] No [] Date joined: _____

Obstetric cover checked? Yes [] No []

Veteran's Affairs Card? []

Permission to contact via SMS / Email if needed? Yes [] No []



MEDICAL RELEASE AUTHORITY

If you agree to Dr Beth Russ, midwife Sam Sayer and / or administration staff discussing the following with your partner or family,

please tick and then nominate name below.

appointments accounts medical condition

Name: _____ Relationship: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

FEES & CONSENT:

I understand that the fees charged will be above the Medicare schedule and I hereby accept responsibility for payment of these fees and any costs incurred in the collection of them.

The practice complies with current legislation regarding the collection, use, security, and disclosure of personal information.

Your consent is required to collect personal information about you.

I understand that I do not have to provide information, but failure to do so may compromise the quality of treatment I receive.

Signed: _____ Date: _____