

EX. 257

PATIENT DETAILS

COPY FOR YOUR INFORMATION

DR MR MRS MISS MS

SURNAME: ROBERTS-SMITH

GIVEN NAMES: BENJAMIN

DATE OF BIRTH: [REDACTED]

ADDRESS: [REDACTED] QLD

POST CODE: 4556

TELEPHONE:(H): [REDACTED] (W): [REDACTED]

MOBILE: [REDACTED] EMAIL: [REDACTED]

OCCUPATION: Media

MEDICARE/DVA NUMBER: [REDACTED]

EXPIRY DATE: [REDACTED] NUMBER (next to name) ON CARD: [REDACTED]

REFERRING GP: [REDACTED]

KNOWN ALLERGIES: [REDACTED]

CURRENT MEDICATIONS (including Herbal/Homeopathic treatments) [REDACTED]

Are you happy for our office to correspond with you via SMS/email or home phone in regards to appointment confirmations or alterations (please circle): Yes/No

As we will only make 1 call to you on the above number, do we have your permission to leave a message at this number? Yes

FULL PAYMENT OF CONSULTATION IS PAYABLE AT TIME OF CONSULTATION

I accept that where 24 hours notice is not given by me prior to cancellation, or failure to attend the appointment a \$7 fee will be incurred.

PATIENT'S SIGNATURE: [Signature]

DATE: 12/12/11