SOUTH COAST SPECIALISTS

Dr Shella De Robles
General and Colorectal Surgeon

South Coast Specialists 2/81 Market Street WOLLONGONG NSW 2500
Surgical Specialists Shoalhaven 32 Shoalhaven Street NOWRA NSW 2541

1300 644 824 (02) 8252 2064 drshelladerobles@gmail.com drshelladerobles.com

PERSONAL INFORMATION

Mr / Mrs / Ms / Miss / Other: _____	
Surname:	First Name:
Preferred Name:	
Home Phone:	
Mobile Phone:	
Date of Birth:	
Email:	

RESIDENTIAL ADDRESS

Address:	
Suburb:	
State:	Postcode:

NEXT OF KIN / CARER

Name:	Mobile Phone:
Relationship to NOK/Carer:	

MEDICARE, HEALTH FUND, DVA, PENSION

Medicare No: ____ ____ ____ ____ – ____ ____ ____ ____ ____ – ____	____
Medicare Expiry:	Ref #
Health Fund:	HF Membership No:
DVA No:	DVA Color:
Pension No:	

GENERAL PRACTITIONER

GP Name:
Clinic Name:
Clinic Address:

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PRIVACY, CONSENT, AND FINANCIAL INFORMATION

To whom it may concern,

I, _____ DOB: _____,

(Full Name) (Date of Birth)

of _____.

(Address)

give permission for Dr De Robles to:

- have access to medical results, information and/or specimens necessary for the management of my medical condition/s.
- release my medical information to other health professionals exclusively for the ongoing management of my medical condition/s. This includes: medical specialist forums called Multidisciplinary Team (MDT) meetings which occur at regular intervals.

I agree with the following financial matters:

- Pay all clinic consultation accounts on the day of my appointment. Consultation accounts can be lodged with Medicare Australia for rebate purposes.
- If I hold a private health insurance, procedure accounts will be billed directly to my health fund (where applicable). If, for any reason, my health fund does not cover the full amount, I agree to settle any outstanding balance within 14 days of receiving the account.
- For self-funded patients, I agree to settle all procedure accounts no later than 7 days prior to the procedure date.

I give permission for the following person(s) to speak with Dr De Robles regarding my medical history, treatment, and condition:

- ☐ Nominated next of kin
- ☐ Carer
- ☐ Other: _____

Signature:		Date:	DD / MM / YYYY