Suite 4, Level 3, 2 Meredith Street
BANKSTOWN NSW 2200
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E: sleepinfo@drdavidfreiberg.com.au

Surname:	Address:
First Name:	
DOB: DD / MM / YYYY	Suburb:
(H) Phone Number:	State:
(M) Mobile Number:	Post code:

BOOKING FORM

Medicare Card Number		Reference:	Expiry Date:
Pension Card Number		Expiry Date:	
Healthcare Card Number		Expiry Date:	
Health Fund Number		Health Fund Name	

MEDICAL HISTORY:

(Please answer all questions and mark YES/No in the appropriate column and circle)

Do you suffer or have you suffered from any of the following?	YES	NO		YES	NO
Asthma/ Use Puffers			Chest Pain/ Heart Problems		
Diabetes (Specify Type)			Blood Pressure High/Low		
Depression/ Dementia/ Anxiety/ Schizophrenia			Epilepsy/ Fits/ Seizures		
Allergies (Please list)			Have you been hospitalized in the last 2 months?		
Do you have a mobility aid like walking stick/ frame/ scooter/ wheelchair			Do you need assistance to transfer from bed or chair		
Infectious Diseases like MRSA/ Golden Staph/ VRE/Hep A, B or C/ Other:			Other:		

MEDICATIONS:

(please list your medications)

Next of Kin:

Name:	Phone No:	Relation:

Patient Signature:	Date: