Northwest Surgeons

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PATIENT REGISTRATION FORM

Title: Mr/Mrs/Ms/Miss/Master/Other. (optional-please choose)
Your Name: _____
Your date of birth: _____
YourAddress:_____
Your Phone/Mobile:_____
Your Email Address:_____

MEDICARE CARD: _ _ _ _ _ _ _ _ _ _ REF: 1 2 3 4 5 Valid to _ _ / _ _ _ _
Do you want us to send your receipt to Medicare for electronic payment? YES/NO
Private Health fund name: _____ Fund no. _____
Department of Veteran Affair's Number:_____ Colour:_____

Who is your family Doctor?_____
Name of clinic and suburb your family doctor is located: _____

Who is your Next of Kin? _____
What is your Next of Kin phone ?_____

YOUR MEDICAL HISTORY:

Are you Diabetic? (YES/NO).
Are you on blood-thinning medications? (YES/NO)
Have you had any heart surgery? (YES/NO)
Do you have a pacemaker? (YES/NO)
Do you have any significant allergies? (YES/NO) Please list:_____

Financial Consent: I have been informed of the fee for my consultation today (please confirm with reception if needed). I agree to pay this amount by the end of the consultation. I understand that if I opt for surgery in the public system, my public surgical booking form will be submitted to the hospital only after my account has been settled.

Disclosure Consent: I consent to sharing my medical history with medical and allied health practitioners, as well as organisations, but only to the extent necessary to assess or treat the condition for which I consulted the surgeon.

Signed:_____Dated:_____