

Personal Details	
Title: _____ Surname: _____	Given name: _____
Address: _____	
Suburb: _____	Postcode: _____
DOB: ____ / ____ / _____	
Mobile: _____	Home Phone: _____
Email: _____	Work Phone: _____
Medicare/Health fund	
Medicare Number: _____	Patient Ref No: _ Expiry: __ / _____
Hospital Fund: _____	Membership Number: _____
Level of Cover: _____	Have you served waiting period: _____
DVA: Status: _____	Number: _____
If this is a Work Cover/TAC Claim please provide details: _____	
Next of Kin	
Surname: _____	Given Name: _____
Contact number: _____	Relationship: _____
GP/Family Doctor	
Name: _____	Phone: _____
Address: _____	

Medical History	
<b>Are you a current smoker?</b> If yes, how many do you smoke a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Are you a past smoker?</b> If yes, when did you cease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you drink alcohol?</b> If yes, volume: _____ Frequency: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you have a pace maker or internal defibrillator?</b> Details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medications & Allergies
<b>Please list <u>all</u> medications you are currently taking (including herbal &amp; vitamins):</b>
<b>Please list all allergies:</b>

**PRIVACY AND PERSONAL INFORMATION:(Please read carefully)**

In the course of managing your health/medical issues/personal information Mr Mehrdad Nikfarjam or his representatives in this practice may need to collect personal information about you for the purpose of providing the best possible care.

In the course of managing your health/medical issues/personal information they also may need to disclose your personal information to: other health professionals, rehabilitation services, employers, and government entities where there are obligations under law to do so.

**SIGNED CONSENT**

I .....  
(write full name)

of .....  
(full private address)

Date of birth ...../...../.....

I hereby authorise and consent to any doctor, health professional, hospital or other health institution or rehabilitation provider which has examined me to discuss with and provide Mr Mehrdad Nikfarjam or any of his representatives in this practice any reports, clinical notes or relevant information in relation to my health.

I understand that the medical information is required for the purpose of assisting with my medical treatment.

I authorise and consent to a photocopy of this Authority being sufficient evidence of my authority and consent to discuss or provide medical information requested.

Please select if you would like to be included in the contact list for PANCARE Foundation, a not-for profit organisation dedicated at pancreatic, liver, biliary and foregut cancer awareness, research and education. You can always choose to be removed from this list in the future.

YES

No

Signature ..... Date ...../...../.....  
(patient)