Patient Registration Form

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

Are you a current smoker? If yes, how many do you smoke a day?	☐ Yes	☐ No
Are you a past smoker? If yes, when did you cease?	☐ Yes	☐ No
Do you drink alcohol? If yes, volume: Frequency:	☐ Yes	☐ No
Do you have a pace maker or internal defibrillator? Details:	☐ Yes	☐ No

Height: _____ **Weight:** _____

Medications & Allergies

Please list <u>all</u> medications you are currently taking (including herbal & vitamins):

Please list all allergies:

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)

How did you find out about LPB Surgery Group?
☐ Google Search ☐ Facebok ☐ Instagram

☐ Doctor's Referral ☐ Other, please specify .....