Mr MEHRDAD NIKFARJAM MD, PhD, FRACS
Liver, Pancreas and Biliary Surgeon
Laparoscopic Surgeon
Provider no. 223166LJ

Correspondence and appointments
66 Darebin Street, Heidelberg VIC 3084
T 03 9458 5100 **F** 03 9458 5199
AH 03 9496 5000 **pager** 2816
E info@lpbsurgery.com

PATIENT REGISTRATION FORM

MR/MRS/MISS/MS.....
(Given names) (Surname)

DATE OF BIRTH..... ADDRESS.....
.....POSTCODE .....

EMAIL: .....

PHONE:
(H).....(B).....(M).....

MEDICARE NO.....Ref No (eg 01, 02)..... Valid to .....
./.....

VETERANS' AFFAIRS NO.....GOLD CARD or WHITE CARD

(please circle)

PRIVATE HEALTH FUND - PRIVATE HOSPITAL COVER - YES or NO (please circle)

FUND
NAME.....NUMBER.....

LEVEL OF COVER...../ MEMBERSHIP OVER 12 MONTHS - YES or NO
(please circle)

NEXT OF KIN
NAME.....RELATIONSHIP.....

ADDRESS.....

PHONE
(H).....(B).....(MOB).....

DOCTORS'

REFERRING
DOCTOR.....(PH).....

ADDRESS
.....

.....

GP/FAMILY
DOCTOR.....(PH).....

ADDRESS.....

.....

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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...../...../.....

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 m y 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.

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

☐ Please tick 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.