melbourne
gastro-
oesophageal
surgery

www.mgos.com.au
www.melbweightloss.com.au

PATIENT REGISTRATION FORM

1. Personal details

Title: ..... Name: .....

Address: Street: .....

Suburb: ..... Postcode: .....

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

Phone number: Home: ..... Work: ..... Mobile: .....

Email: .....

Occupation: .....

Next of kin: Name: ..... Relationship: .....

Address: .,.....

Phone number(s): .....

2. Referring doctor information:

Name: ..... Phone: .....

Address: .....

Usual GP:

Name: ..... Phone: .....

Address: .....

3. Insurance details (please complete all relevant fields)

Medicare details:

Number: ___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___

Reference number: ___ Expiry: ___ ___ / ___ ___ ___ ___

Health insurance details:

Company: ..... Policy number: .....

Pension details:

Pension number: ..... Expiry: .....

Health care card number: ..... Expiry: .....

DVA Number: .....

Workcover claims:

Claim number: .....

Insurance company: .....

Responsible employer: .....

4. Medical history

Previous medical conditions e.g. asthma, diabetes, heart disease

1 ..... 2 ..... 3 .....

4 ..... 5 ..... 6 .....

7 ..... 8 ..... 9 .....

Current medications (including over the counter medication)

1 ..... 2 ..... 3 .....

4 ..... 5 ..... 6 .....

7 ..... 8 ..... 9 .....

Please list any allergies and the specific reaction.

1..... 2 ..... 3 .....

List all previous operations

1 ..... 2 ..... 3 .....

4 ..... 5 ..... 6 .....

Height: Weight:

Are you a smoker?

☐ Never smoked ☐ Ex smoker: How long ago did you stop?.....

☐ Current smoker: No. per day? How many years smoked?

How much alcohol do you drink? .....

5. How did you find out about us?

☐ From your referrring Doctor ☐ Internet Search

☐ On our Facebook page ☐ Health Engine

☐ Other, please specify_____

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INFORMATION CONSENT FORM

We require your consent to collect personal information about you. Please read this document carefully and sign where indicated below.

This medical practice collects patient information for the primary purpose of providing quality health care. We require your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals
- Disclosure to other doctors in this practice, locums and registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will make a note in your record accordingly
- Research, audit and other quality assurance activities to improve individual and community health care and practice management

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I have read the information above and understand why information must be collected. I am aware that this practice has a privacy policy on handling patient information. The privacy policy can be found on our website or a hardcopy can be obtained upon request.

I understand that I am not obligated to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access may legitimately be withheld. I understand I will be given an explanation in these circumstances.

I may request an amendment to my personal information if it is incorrect. I will be provided with a written reason if a request for amendment is denied.

I understand that if my information is to be used for any other purpose other than described out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of. I have the right to lodge a complaint about the handling of my personal information if I am dissatisfied, which will be dealt with in accordance with the our complaint handling procedure

Patient name: ..... Date: .....

Signature: .....