Patient Registration

Surname: ..... Given Names: ..... Dr/Mr/Mrs/Miss/Ms

Preferred Name: ..... Date of Birth: ...../...../..... Email: .....

Address: ..... Marital Status: .....

..... Post code: ..... Occupation: .....

Phone: (H) ..... (W) ..... (Mob) .....

Next of Kin / Partner's Name: ..... Relationship: .....

NOK Contact numbers: (H) ..... (W) ..... (Mob) .....

Health Insurance fund: ..... Number: .....

Medicare number: ..... Ref. Number (before your name): .....

Veterans Affairs / Pension / HCC (please circle as appropriate) Number: .....

Referring Doctor: ..... Usual GP: .....

Please indicate any major illnesses/ operations in past: .....

.....

Do you take any "blood thinners" e.g. Warfarin, Clopidogrel, Aspirin, Iscover? ❑ Yes ❑ No

Please list other medications (including "natural therapies"): .....

Please list any allergies: .....

The fees charged in this practice exceed the Medicare Benefit Schedule (MBS) fee. Patients who require hospital procedures will be provided with informed financial consent. Payment on the day of consultation is expected. Non payment of accounts will result in your account being forwarded for debt collection by an external agency. Any fees incurred in collection of accounts will be passed onto the patient.

All personal information is handled in accordance with the practice's privacy policy and consistent with the privacy legislation.

Dr Thomas is involved in teaching other specialists and gynaecologists in training. Occasionally de-identified clinical material including digital images obtained in surgery may be used.

I have read and understand the above arrangement of fees.

Signature: ..... Date: .....