melbourne gastro-oesophageal surgery

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PATIENT REGISTRATION FORM

1. Personal details

Title:	Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr ☐ Other _____	
Name:		
Address:	Street:	
	Suburb:	Postcode:
Date of birth:		
Phone number:	Home:	Work:
	Mobile:	
Email:		
Occupation:		
Marital status:		
Next of kin:	Name:	
	Address:	
	Phone number:	Relationship:

2. Referring doctor(s) information
(Skip this section if these details are contained in your referal letter)

Referring doctor:	Name:
	Address:
Your usual GP:	Name:
	Clinic:
	Address:
	Contact number:

PLEASE TURN OVER

3. Insurance details (please complete all relevant fields)

Medicare card:	Number: __ __ __ __ - __ __ __ ____ - ___	
	Reference number: ____	Expiry: __ __ / __ __ __ __
Health insurance:	Company:	Policy number:
Pension:	Number:	Expiry:
Health care card:	Number:	Expiry:
DVA:	Number:	
Workcover claims:	Claim number: Insurance company: Responsible employer:	

4. Previous medical history

This questionnaire helps us provide the best surgical care. All information is recorded in a secure database and is STRICTLY CONFIDENTIAL.

Previous medical conditions e.g. asthma, diabetes, heart disease	Current medications (including over the counter medication)	
1.	Name	Dose
2.		
3.		
4.		
5.		
List all previous operations		
1.		
2.		
3.	Do you have any allergies?	
4.	Allergen	Reaction
5.		
Are you a smoker?		
How many cigarettes do you smoke a day?		
How many years have you been a smoker?		
Height:	Weight:	