GASTRONORTH
GASTROENTEROLOGY & ENDOSCOPY

Gastro North Patient Registration Form

Title: First Name	Address
Surname	Suburb Postcode
Date of Birth (dd / mm / yyyy) Age Sex ☐ M ☐ F	State Country
Mobile: Home Phone	Work Phone:
Email Address:	
Are you Diabetic ☐ Yes ☐ No Do you take: Insulin ☐ Yes ☐ No Tablets ☐ Yes ☐ No	

Medicare Number ___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___	(___) Number in front of name	Valid to: mm / yyyy
Private Health Insurance Fund: **Membership No:**	**Is your cover for a Private Hospital: Yes No** Have you been in your fund **LESS** than one year: **Yes No**	
Blue Pension Card Holder	Ref No ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	
Veterans Affairs Card Holder ☐ Yes ☐ No	DVA Number	Expiry ____/____
WORK COVER/TAC RELATED ☐ Yes ☐ No		
INSURANCE COMPANY:	WORK COVER CLAIM NUMBER:	
REFERRING DOCTOR NAME:	Phone Number:	
REFERRING DOCTOR ADDRESS:	Suburb:	
LOCAL DOCTOR **(if different to referring doctor)** NAME:	Phone Number:	
LOCAL DOCTOR ADDRESS:	Suburb:	
LIST ANY SPECIALISTS CURRENTLY SEEING: NAME:	Phone Number:	
NEXT OF KIN OR EMERGENCY CONTACT:		
RELATIONSHIP TO PATIENT CONTACT PHONE NUMBER	Home:	Mobile:

CONDITIONS OF TREATMENT

Payment is required on the consultation day. Should payment not be made on the day I acknowledge I will pay any additional account fees/ charges that may be incurred until account is paid in full. I understand it is my responsibility to ensure a current referral

PRIVACY PATIENT INFORMATION

To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other healthcare providers with the patient's consent. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your doctor.

Signature of patient or guardian.	Date