GASTRONORTH
GASTROENTEROLOGY & ENDOSCOPY

GastroNorth Patient Registration Form

Title First Name	Surname
Address	Suburb Postcode
Date of Birth (dd / mm / yyyy) Age Sex ☐ M ☐ F	State Country
Mobile:	Home Ph:

Email Address:

Are you happy for us to communicate with you via email: YES // NO

Are you Diabetic? ☐ Yes ☐ No If yes Insulin or Tablets Please circle.

Medicare Number ___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___ Colour of Medicare card: GREEN or BLUE Please circle	(___) 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 ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	
DVA Card Holder ☐ Yes ☐ No Colour of DVA card: GOLD or WHITE Please circle	DVA Number	Expiry ____/____

OVERSEAS PATIENTS - Private Health Insurance Fund: Please circle YES or NO

Name of fund Private Health Fund:

WORK COVER/TAC RELATED ☐ Yes ☐ No

INSURANCE COMPANY: WORK COVER CLAIM NUMBER:

REFERRING DOCTOR NAME: Phone Number:

REFERRING DOCTOR CLINIC ADDRESS: Suburb:

Regular GP Name: Phone Number:

Clinic:

NEXT OF KIN OR EMERGENCY CONTACT:

EMERGENCY CONTACT PHONE NUMBER Home: Mobile:

How did you hear about us? ☐GP ☐Via website ☐Word of mouth ☐Facebook /Instagram ☐Other

☐ Please tick if you would like our updates & tips for great gut health

☐ Please tick if you do not wish to be contacted for feedback

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.

CANCELLATION POLICY

If for any reason you need to reschedule or cancel any future appointments we will require 48 hour notice or you may be charged a $50 late cancellation fee.
We often have a long waiting list of patients and this timeframe allows us to offer your appointment to other patients.

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**