NEW PATIENT REGISTRATION FORM

PATIENT DETAILS		
Title:	First Name:	Surname:
Date of Birth:	Mobile:	Home:
Home Address:		
Email Address:		

GP DETAILS
GP Name:
Medical Centre Name:
Contact Number:
Address:

NEXT OF KIN / EMERGENCY CONTACT	
Name:	
Mobile:	Home:
Relationship:	

MEDICARE DETAILS		PRIVATE HEALTH FUND DETAILS
Number:	Ref #:	Name of Fund:
Expiry:		Membership Number:

Please indicate if you have experienced any of the following conditions:

☐ High/Low BP	☐ Migraines/Headaches	☐ Fluid Retention
☐ Heart Problems	☐ Fainting/Blackouts	☐ Vertigo
☐ Thrombosis/circulatory condition	☐ Cancer	☐ Deep Vein Thrombosis
☐ Haemophilia/bruising	☐ Varicose Veins	☐ Skin Condition

Do you have any other diseases or conditions that you are aware of? Yes ☐ No ☐

If yes, please list:

PRIVACY POLICY

To provide a high standard of health care we need to collect personal information from our patients. All persons accessing your health information are bound by confidentiality. Please do not hesitate to discuss any concerns related to the privacy of your personal information with your clinician. We ask for your consent to discuss your case with other health care providers should that be required to assist in your treatment:

☐ I consent to the use of my personal health information by Yarra Vascular Surgeons and other health providers involved in my medical treatment and health care

☐ I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment

Signature of patient/guardian:...Date:......................................

How did you find out about Yarra Vascular Surgeons?		
☐ Family recommendation	☐ Friend Recommendation	☐ My GP Practice
☐ YVS Website	☐ Search Engine (Please specify)	
☐ Other (please specify)		