EDWARD STREET OBSTETRICS AND GYNAECOLOGY
PATIENT
REGISTRATION FORM

Title: Given Name(s): Surname:

Parent/Guardian (if under 16 years):

Postal Address:

Date of Birth: Occupation:

Religion (optional):

Home Ph: Work Ph: Mobile Ph:

Email Address:

Next of Kin: Relationship: Phone No:

Family Doctor: Name of Practice:

Pension Number:

Medicare Number: Reference Number: Expiry Date:

Department of Veteran's Affairs Card number: ☐ Gold ☐ White

Do you have Private Health Insurance? ☐ No ☐ Yes, name of fund:

Fund ID/Number: Expiry Date:

Do you have mature obstetric health cover? ☐ No ☐ Yes

Please mention any restrictions/limitations on your health insurance/obstetric cover:

Medical History:

Operations:

Hospitalisations:

Illness:

Injuries:

Do you have any allergies (tapes, creams, medications)?

Please list all medication you are taking:

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Previous Pregnancies: ☐ No ☐ Yes

Mode of delivery: ☐ Normal ☐ Instrumental ☐ Caesarean

Complications: ☐ No ☐ Yes

If yes, please list:

Briefly describe what you would like help with today:

Is there family history of any concern?

How did you hear about our clinic?

☐ Our Signage ☐ Family/Friend

☐ Internet search/Google ☐ Facebook

☐ Doctor/Health Professional

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CONSENT FORM

I consent to the following.

Any of my medical records, results, images, photos or information necessary for further treatment may be forwarded to appropriate medical practitioners, health professionals or third parties (such as accreditation agencies or as required or authorised by law e.g., court subpoenas)

General physical examination, head and neck, breast, chest, abdomen, pelvic, gynaecological examination and transvaginal and transabdominal ultrasound where applicable. I understand that pelvic and gynaecological examination/s may be the priority of my consultation. I understand that ultrasound findings will be interpreted to the doctor's knowledge and skills and that I may be informed of normalities and abnormalities, which may be under diagnosed or over diagnosed.

I am liable and accept personal responsibility for full payment of doctors' fees. I will be responsible for full payment of doctors' fees and hospital fees in the event that my claim is rejected by my health fund or in the event of being uninsured while inpatient.

I consent to the possibility that I may be seen by a medical midwife/nurse/allied healthcare professional/ student under the supervision of our doctors for examination/educational/teaching purposes.

I consent to having my baby's photos & testimonials displayed in our rooms and websites.

I understand that payment is expected at the time of all appointments and that no account receipts will be issued until paid in full. Any outstanding accounts which are not attended may be forwarded to a legal and debt collection agency and additional fee, legal charges, debt commission may be charged until full payment is made.

I have read and understood the privacy policy provided and agree to the Terms and Conditions.

Patient full name:

_____

(Or guardian's name if patient is under 16)

Signature_____ Dated: _____