

New patient form

CAPRICORN OBESITY
& GENERAL SURGERY

Surgical excellence with compassion



Your details

About you

Title _____

Given Names _____ Preferred Name _____

Surname _____ DOB / / _____

Contact

Mobile Phone _____ Home Phone _____

Email _____

Address

Street _____

Suburb _____ State _____ Postcode _____

Postal Address (If not same as Residential Address) _____

Health fund and insurance

Medicare

Number _____

Ref _____ Exp / / _____

Private Health Fund

Fund Name _____ Fund Number _____

DVA

DVA Card Holder YES NO

Card Type _____ Card Number _____ Exp / / _____

Health Care Card or/and Pensioner Card Holder YES NO

Card Number _____ Exp / / _____

Next of kin

Name _____ Relationship _____

Phone _____ Regular GP _____

Privacy

The medical information collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assist, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways: Administrative purposes in running our medical practice; Billing purposes, including compliance with Medicare and Health Insurance Commission requirements; Disclosure to others involved in your health care; Disclosure to other doctors in the practice including our reception staff; We are involved in Research Studies, which involve collating medical information for the purposes of auditing and quality assurance. All personal details involved in research and quality assurance are deleted and therefore you will remain anonymous; Emergency situations where medical officers/hospitals require access to patient notes for treatment purposes.

Signature _____ Date / / _____

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