As a new patient to the practice we ask that you complete the below patient registration forms.
Please return these to us as soon as possible by either email (admin@ponoshvascular.com.au) or in person.

PATIENT REGISTRATION FORM

Title: __________ **First Name:** ____________________________ **Surname:** ____

Address: ____

Suburb: ____ **State:** _________________________________ **Postcode:** __________

Date of birth: ____________________________________ **Occupation:** ____

Mobile: _________________________ **Home:** __________________________ **Work:** _________________________________

Email Address: ____

Medicare No: _____________________________ **Reference No:** ___________________ **Expiry Date:** ______________________

Health Fund: ______________________________ **Membership No:** _________________ **Level of cover:** ____________________
For any in-Hospital procedures your level of cover must be Silver or Gold and include Vascular/Cardiac coverage.

Pension/Health Care Card: ____

DVA Card No: _____________________________ **DVA Card Colour:** ________________ **White Card Coverage:** ______________

Usual GP: _________________________________ **Suburb:** __________________________ **Phone:** __________________________

Are there any other medical practitioners you would like to have copied on correspondence? Please list below;

Name **Address** **Phone**

____

____

____

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected.
I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice. CCTV is in operation in our practice.

Signed: ____ **Date:** ____________________________________

Patient Name (Please print): ____

PATIENT NEXT OF KIN DETAILS

First Name: ____________________________ **Last Name:** _____________________________ **Relationship:** _______________________

Phone: ________________________________ **Email:** ____

PATIENT EMERGENCY CONTACT (if different from above)

First Name: ____________________________ **Last Name:** _____________________________ **Relationship:** _______________________

Phone: ________________________________ **Email:** ____

Family members or next of kin often contact Doctors to enquire about a patient's care or proposed treatment. Please advise if you consent to Mr Ponosh or his practice staff to discuss your care and/or medical information with your next of kin.

I, _______________________________ , hereby authorise Mr Ponosh and/or his practice staff to discuss my care with my nominated next of kin and/or my emergency contact person as noted above.

Patient's Signature: ____ **Date:** ________________________

PATIENT MEDICAL HISTORY

Past medical history of vascular relevance or major surgery:

____

____

____

____

Allergies (Please include reactions): **CONTRAST/DYES/SHELLFISH/IODINE**

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____

____

Current medications:

Drug: __________________________ **Dose:** _______________ **Frequency:** __________ **Reason:** __________________________________

Drug: __________________________ **Dose:** _______________ **Frequency:** __________ **Reason:** __________________________________

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Drug: __________________________ **Dose:** _______________ **Frequency:** __________ **Reason:** __________________________________