NEW PATIENT REGISTRATION FORM

Personal Details

Title ☐ Mrs ☐ Miss ☐ Ms ☐ Mr ☐ Dr

First Name

Middle Name

Surname

Date of Birth

Occupation

Australian Resident ☐ Yes ☐ No

Referring GP

Prior Patient ☐ Yes ☐ No

Contact Details

Home Address

Postcode

Postal Address

Postcode

Home Phone

Mobile Phone

Work Phone

Email Address

Medicare

Card Number

Reference Number

Expiry Date

Health Fund

Name of Fund

Member Number

Veteran Affairs

D.V.A Number

Partner / Next of Kin

Full Name

Relationship

Primary Phone

Nominated Person (Who Can Ring on Behalf of Your Results)

Full Name

Relationship

Medical History

Please list any medications you currenty take

Please list any allergies you have

Please list any prior surgical procedures

Please list any medical conditions

Please list any significant family history

Please list any previous pregnancies

Have you had any recent ultrasound or scans ☐ Yes ☐ No

If yes, on what date

Which Company

Have you had any recent blood tests ☐ Yes ☐ No

If yes, on what date

Which Company

When was your last pap smear

Have you had any abnormal pap smears ☐ Yes ☐ No

By submitting this information I hereby consent to necessary examinations and to Dr Flynn using the collected personal and health information in accordance with the privacy act. I authorise Dr Flynn to access and disclose my health information from my referring Doctor / Medical Specialists, allied health practitioners and institutions who may require information about my medical history but only to the extent necessary to access and treat the particular condition. I also understand that this appointment may involve pelvic or vaginal examination and transvaginal ultrasound.

Signed

Date

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