PATIENT REGISTRATION FORM

Miss/Ms/Mrs	Surname	First name	Date of birth

Home address	PO Box (if applicable)
Street	PO
Suburb	Suburb
Postcode	Postcode
Home phone	Mobile phone
Email address	
Occupation	

Medicare number	Reference number (left of name)	Expiry date
Private health fund	Membership number	Type of cover HOSPITAL/EXTRAS/BOTH

DVA file number	Gold card/White card/Other (please specify)
Pension number	Type of pension
GP name	GP's Clinic
GP Suburb	GP's Telephone number
Emergency contact (Next of Kin) Name Relationship	Telephone number
Allergies	

Would you like SMS appointment reminders? YES NO
Would you like email appointment remainders? YES NO
How did you hear about us?

PROF A OBERMAIR – GYNAECOLOGICAL ONCOLOGIST
Level 13, 149 Wickham Terrace, Spring Hill QLD 4000
Phone: 3128 0800 Fax: 3831 6770

MEDICATION LIST

Patient's Name: _____ Date of Birth: ___/___/___

Prior to your surgery, it is extremely important that we are aware of any medication that you may be on the thin out your blood. To help us gather this information, please answer the following questions by putting a ✓in the appropriate box.
Thank You.

DO YOU TAKE ANY PRESCRIPTION MEDICATION? LIST BELOW OR ATTACH YOUR OWN LIST.

NAME	STRENGTH	HOW OFTEN

DO YOU TAKE ANY OVER THE COUNTER MEDICATION (INCLUDING HERBS, SUPPLEMENTS)

DO YOU TAKE ANY BLOOD THINNING MEDICATION NOT LISTED ABOVE?

PLEASE BRING RELEVANT MEDICAL IMAGING FILMS AND REPORTS WITH YOU FOR YOUR CONSULTATION.

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