Dr Namrata Bajra
PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Title:	First Name: (As on your medicare card)	Surname: (As on your medicare card)
DOB:		Preferred Name:
Address:		Suburb:
Postal Address if different from above:		
Home Phone:		Mobile Phone:
Aboriginal: Yes NO TSI: YES NO Are you registered for CTG: YES NO (Closing the gap)		Do you agree to have SMS sent to you to confirm appointments? YES NO
Email:		
Medicare Card:	Ref: (Number next to your name)	Expiry Date:
Private Health Insurance: (Only complete if you have Hospital cover)	Membership Number:	Date Joined:
DVA Card Number:	Pension / Health Care Card:	EXP:
Occupation:	Country of Birth:	

REFERRAL DETAILS:

How did you hear about our practice? GP Friend Internet Website Other
GP you would like correspondence to be sent to:
(Name and Clinic)

PARTNER OR NOK DETAILS:

Next of Kin:	Relationship to you:
Contact Number:	

PATIENT CONSENT

The purpose of this document is to obtain accurate information for your patient record. The practice will only use the information provided for the direct purpose in which it is intended for. Our practice uses medical software to store your medical information, which is only used for the purposes of treating you as a patient. This practice may need to obtain medical information from your other treating practitioners that you provide to us.

This practice will also send a letter to all relevant health care providers including the referring medical practitioner detailing the treatment provided. We will also communicate via email to confirm your appointment information and provide any other information that you may request via email.

I have read the above information and give my consent.

Patient Signature _____ Todays Date: _____

Dr Namrata Bajra
Obstetrician & Gynaecologist
(Dr N Bajra Medical P/L - ABN 59 148 987 035)

Phone: 3353 9090 Fax: 3353 9393 Email: reception@drnbajra.com.au

Request for Medical records

To: .....

Fax: .....

Re:

* I ..... DOB ..... Here by authorise

Dr Namrata Bajra to have a copy of my:

Medical history

OT notes

Pathology results

Radiology results

Other: .....

* Signature: .....

* Date: .....