

Dr Dragos Iorgulescu
General Surgeon

NEW PATIENT REGISTRATION FORM

Title: Mr Mrs Ms Miss Mast

First name:

Surname:

Middle name:

Preferred name:

Maiden name:

Address:

City/Suburb:

State: Postcode:

Date of birth:

Sex: Male Female

Contact details

Home:

Mobile:

Work:

Email:

Do you consent to SMS appointment reminders?

Yes No

Do you consent to Email correspondence?

Yes No

Medicare number:

REF number (next to patient's name)

Medicare expiry date: /

Do you have a Private Health Fund?

Yes No

Name:

Membership number:

Dept. of veterans affairs number:

DVA expiry date: /

Gold card White card Orange card

Conditions:

Do you have a BLUE Pension Card?

Yes No

Customer Reference Number:

Card expiry date: / /

Referring Doctor:

Usual Doctor:

Marital status

Single Married Defacto

Separated Divorced Widowed

Cultural background:

Aboriginal Australian

Torres Strait Islander

Aboriginal Australian and Torres Strait Islander

Australian

Other

Other (please specify):

If you have ticked Aboriginal and/or Torres Strait Islander
please see reception regarding: **Closing the Gap** program

Occupation: Retired

First emergency contact

Name:

Phone number:

Relationship:

Second emergency contact **As above**

Name:

Phone number:

Relationship:

Do you have any allergies and/or are you sensitive to any drugs or dressings?

Yes (please list) Nil known

Allergic to:

Reaction:

List of current medications (if not covered on your current referral):

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Alcohol intake

Drinker Non-drinker Past drinker
Days per week: Drinks per day:
Year started: Year stopped:

Tobacco intake

Smoker Vape Non-smoker Ex-smoker
Days per week: Cigarettes per day:
Year started: Year stopped:

Past Operations (including dates):

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.....

Family history of cancer/ bowel disease (details of type of cancer and family member concerned):

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Significant Health Conditions?

- Heart trouble
- Shortness of breath
- High Cholesterol
- Stroke
- Asthma
- Liver
- Epilepsy
- Anaemia
- Problem with anaesthetic
- Back or hip problems
- Are you on warfarin or blood thinners
- Steroids/cortisone in the last 6 months
- Chest pain/Angina
- Lung disease
- High blood pressure
- Diabetes
- Hepatitis
- Kidney disease
- Bleeding tendency
- Rheumatic fever
- Family anaesthetic issues
- Blood transfusions

Other:
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If I am required to return to Dr Iorgulescu's rooms for an appointment to follow up after a hospital procedure, I understand that full payment is required at the time of the consultation.

Privacy Legislation Australian Privacy Principles 12 March 2014

Due to changes to the Privacy Legislation, when personal details are recorded, patients need to be aware what they will be used for. We therefore seek permission to use details under the following circumstances for the best management of your medical condition. By my voluntary attendance at this Specialist Practice, I understand that Dr Dragos Iorgulescu may use my information for the following purposes:

- Record my personal particulars
- Record notes relevant to the reason for my attendance and past history
- Correspond to General Practitioners, other Specialists and Hospitals and any other relevant health personnel as is needed for the best management of my medical condition
- Reasons that may require release of my personal information may be for legal purposes such as a subpoena or court process or if the release of my personal information may lessen or prevent a serious threat to a person's life, health or safety or to public health or safety.
- Record personal information for accounting purposes and hospital admission
- Arrange diagnostic tests relevant to my condition. Such requests will necessarily contain reference to my personal details.
- Arrange consultant advice, if indicated by Dr Dragos Iorgulescu, to discuss and write to the consultant, including diagnostic reports in the referral along with relevant personal details and allow the practice to retain resulting reports

I have read this form before signing it and understand why collecting information about me is necessary. I understand that if I refuse for my personal information to be recorded or used for the above purposes then I am unable to be medically assisted by Dr Dragos Iorgulescu. I acknowledge that a member of staff, at my request, has clarified any aspects of the privacy legislation.

Signature: **Date:** / /

Parent /Guardian name(if under 16).....