New Patient Registration

Sydney Urogynaecology
SPECIALIST CARE

Title ○ Mrs ○ Ms ○ Miss ○ Dr ○ Prof

Full name

Date of Birth

Age

Address

Home phone

Work Phone

Mobile

Email

Occupation

Medicare No.

No. next to name on Medicare Card

Medicare card expiry date

Department of Veterans Affrairs number

Does it cover all medical expenses?

○ Y ○ N

Government Concession card number

Expiry date

Do you have private health insurance hospital cover?

○ Y ○ N

Health fund name

Member number

Have you served the one year waiting period with your health fund?

○ Y ○ N

Next of kin

Relationship

Contact phone number(s)

Regular GP name (if different from referring doctor

Clinic name and address

Clinic phone

Health Questionnaire

Sydney Urogynaecology
SPECIALIST CARE

Reason for your visit

Other current medical complaints/disorders

Past medical history

Previous major surgeries

Current medications/herbal medicines (unless listed on referral)

Drug allergies/reactons

Obstetrics (pregnancies/births)

Do you smoke? (if so, how many per day)

Do you consume alcohol? (If so, how many standard drinks per day/week)

Do you consume caffeine (Tea/Coffee)? (If so, what and how many per day)

How many glasses of water do you consume per day?

This practice is committed to ensuring high level privacy for personal health information collected, used and disclosed in the course of effective patient care. During this process, both collection and sharing of information with other treating practitioners may be necessary. Should your health information be required for other purposes, your further consent will be required.

Financial Consent

The policy of this practice is payment on the day of consultation. If payment presents a difficulty, please speak with the secretary before your consultation. If you do not have private health insurance (hospital cover), please be aware that procedures requiring admission to Hospital will generate significant out of pocket costs if you choose to go ahead with the procedure.

☐ I understand and agree to the above billing procedures. I acknowledge that if an account is overdue, Dr Gopinath reserves the right to refer the account to a third party. I agree to meet all reasonable costs incurred by Dr Gopinath, in employing the third party to collect any overdue accounts.

Full name:

Signature:

Date:

Once completed, please email this to info@sydneyurogynaecology.com.au or hand in at our reception desk.