Dr Nasreen Shammas

PATIENT REGISTRATION & CONSENT FORM

MR / MRS / MS / MISS / OTHER: ___________________

First Name: _____________________ **Surname**: _______________________

Date of Birth: ____/____/_______ Male ☐ Female ☐

Address: ____

Suburb: ________________________________ State: ________ Postcode: _________

Telephone: Home: __________________________ Mobile: ______________________

Email Address: ____

Medicare No											**REF**	

Expiry Month		**Expiry Year**	

Pension Card Number: ________________________ **Expiry Date:** __________________________

Health Fund Name: ___________________________ **Membership No:** ______________________

DVA Number: _______________________________ **Expiry Date:** ___________________________

IN THE CASE OF AN EMERGENCY:

Name: _____________________________________ Relationship: _____________________

Contact Number: ___________________________

How did you hear about us? GP/Specialist Family/Friend Internet Social Media Others

Privacy Information and consent:

I consent to Dr Nasreen Shammas' surgery storing the information I have provided on this form. I understand that this information will be stored through paper record and also a computerised Database. YES / NO

I give my consent to Dr Nasreen Shammas' surgery using the information I have provided to issue letters to me reminding me when my routine Health Checks are due. I understand that my doctor will discuss the Health Checks I need, if any, as part of my consultation. Also, I give my consent to Dr Nasreen Shammas' surgery to provide letters to my referring doctor. YES / NO

In the event that I am required to be referred for further testing and/or Investigations or to a specialist, I give my consent to my doctor disclosing essential personal and health information for that purpose. YES / NO

I give my consent for internal examination of my genital area if required. YES / NO

I give my consent for a cervical screening test to be collected if required. YES / NO

I give my consent for a colposcopy + Biopsy to be performed if required. YES / NO

Patient's Signature		**Date**	