melbourne
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surgery

www.mgos.com.au
www.melbweightloss.com.au

PATIENT REGISTRATION FORM

1. Personal details

Title: .... Name: ....

Address: Street: ....

Suburb: .... Postcode: ....

Date of birth: ..../................./................

Phone number: Home: .... Work: .... Mobile: ....

Email: ....

Occupation: ....

Next of kin: Name: .... Relationship: ....

Address: .,..

Phone number(s): ....

2. Referring doctor information:

Name: .... Phone: ....

Address: ....

Usual GP:

Name: .... Phone: ....

Address: ....

3. Insurance details (please complete all relevant fields)

Medicare details:

Number: ___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___

Reference number: ___ Expiry: ___ ___ / ___ ___ ___ ___

Health insurance details:

Company: .... Policy number: ....

Pension details:

Pension number: .... Expiry: ....

Health care card number: .... Expiry: ....

DVA Number: ....

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Workcover claims:

Claim number: ....

Insurance company: ....

Responsible employer: ....

4. Medical history

Previous medical conditions e.g. asthma, diabetes, heart disease

1 .... 2 .... 3 ....

4 .... 5 .... 6 ....

7 .... 8 .... 9 ....

Current medications (including over the counter medication)

1 .... 2 .... 3 ....

4 .... 5 .... 6 ....

7 .... 8 .... 9 ....

Please list any allergies and the specific reaction.

1.. 2 .... 3 ....

List all previous operations

1 .... 2 .... 3 ....

4 .... 5 .... 6 ....

Height: Weight:

Are you a smoker?

☐ Never smoked ☐ Ex smoker: How long ago did you stop?.....................

☐ Current smoker: No. per day? How many years smoked?

How much alcohol do you drink? ....

5. How did you find out about us?

☐ From your referrring Doctor ☐ Internet Search

☐ On our Facebook page ☐ Health Engine

☐ Other, please specify_______________________