Dr Maged Aziz
MBChB, FRACS
Vascular and Endovascular Surgeon

ADVANCED Vascular
vascular and endovascular surgery

New Patient Details

Personal Details

Name:	**Date of birth:**	
Address:		
Home Phone:	**Mobile Phone:**	
Email:		
Next of kin:	**Relationship:**	
Address:	**Mobile:**	
How did you hear about us?	Internet ☐	Family/friends ☐
	Newspaper ☐	Doctor ☐

Insurance

Medicare card number:	**Reference number:**	
Health fund:	**Membership number:**	
Member since:		
Pensioner/ HCC number:		
DVA number:	**Gold/white**	**Expiry date:**
Referring doctor:	**Phone:**	**Post code:**
Address:		

To comply with the Privacy Act 2001, all patients need to provide written consent for the following important aspects of their medical care.

• I agree that Dr Aziz takes a full medical history that relates to my medical condition and management.

• I agree that relevant information may be obtained from other medical practitioners, such as GP's and specialists, other health care providers, pathologists, hospital and Day Surgery Units as necessary.

• I agree that Dr Aziz may discuss my medical history, diagnosis and management with my General Practitioner and other relevant Medical Specialists in relation to my medical management.

• I understand that I may apply to access my health records. I agree to receive electronic communication.

Patient Name: ..... Signature: ..... Date ...../...../.....