



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

Health fund:		
Member since:	Membership number:	
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/...../.....