Professor Helen O'Connell AO
Urological Surgeon
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PATIENT REGISTRATION FORM

Please print clearly and complete all relevant sections

Mr / Mrs / Ms / Miss / Dr / Prof

PATIENT NAME_____

DATE OF BIRTH_____**EMAIL**_____

ADDRESS_____

SUBURB_____**POST CODE**_____

HOME_____**MOBILE**_____**WORK**_____

OCCUPATION_____

NEXT OF KIN_____**CONTACT NO**._____

MEDICARE _ _ _ _ _ _ _ _ _ _ _ **REFERENCE NO.**____ **EXPIRY** _ _ / _ _

PRIVATE HEALTH INSURANCE YES / NO **if joined in the last 12 months, please provide date joined

HEALTH FUND_____**MEMBER NUMBER**_____

DEPARTMENT OF VETERAN AFFAIRS **NUMBER**_____**COLOUR**_____

REFERRING DOCTOR_____

GP NAME_____**PRACTICE NAME**_____

ADDRESS_____

Any other SPECIALISTS involved in your care_____

ALLERGIES_____

CURRENT MEDICATIONS_____

DO YOU TAKE ASPIRIN/ WARFARIN or any other ANTICLOTTING DRUGS REGULARLY? NO/ YES _____

Have you viewed Prof O'Connell's website? YES / NO

<u>Please read the following paragraph carefully, sign and date.</u>

I, _____authorise the release of my medical records from existing and past health care providers to my treating doctor for my current care and future treatment.

SIGNATURE_____**DATE**_____