Dr Nicholas Lotz **Confidential Patient Registration**

Title: .... Surname: .... First Name: ....

Address: ....

Date of Birth: .... Phone: H .... MOB: ....
Email Address: ....

Medicare No: .... Pt Ref No: ..... Expiry Date: ....
Health Fund Name: .... Membership No: ....

Your next of kin details (family member or friend/ medical power of attorney):
Name: .... Relationship to you: ....
Contact Number: ....

Name of General Practitioner.. Phone: .... Address:
....

Do you have or have had any of the following?

☐Anaesthetic problems ☐Arthritis ☐Asthma ☐Bad scars
☐Bleeding problems ☐Blood clots ☐Cold sores ☐Diabetes
☐Healing problems ☐Heart problems ☐Hepatitis ☐High blood pressure
☐HIV/AIDS risk ☐Psychiatric treatment ☐Spinal/neck problems

Please list current illnesses:...
....
List current medications:
(include aspirin, cortisone, steroids, anti-inflammatory, warfarin, fish oil, herbal products and over-the-counter preparations)

....
....
Do you smoke? ... How many per day?............ Alcohol intake: .... drinks per day

Allergies: ....
Previous operations: ....
....

Are you happy for copies of the correspondence which is sent to the referring doctor to be also sent to your GP and any other treating doctors? Yes No (please circle your answer)

Do we have your permission to obtain copies of relevant medical records such as ECGs, pathology, X-rays, letters and reports that pertain to your surgery? Yes No (circle)

Do we have your permission to forward any relevant medical records to a Doctor or medical/administrative personnel who are involved in your care? Yes No (circle)

I have sighted the Privacy Policy: Yes No (circle)

Signature: .... ***Date:*** ....