

New Patient Details

Dr Maged Aziz
MBChB, FRACS
Vascular and Endovascular Surgeon

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.

Patient Name:

Signature:

Date/...../.....