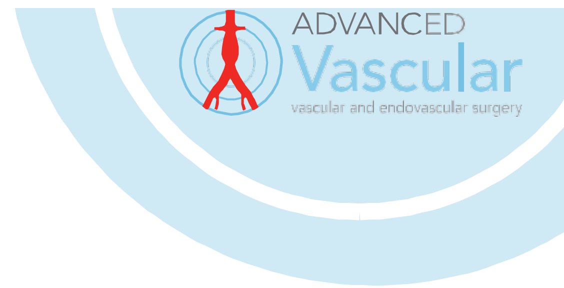
Dr Maged Aziz
MBChB, FRACS
Vascular and Endovascular Surgeon



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 ...../......./..........