DR SAMINA AHMED
OBSTETRICIAN & GYNAECOLOGIST

New Patient Registration Form

Title: Ms Mrs Miss

Surname: (as per Medicare Card): _____

First Name (as per Medicare Card): _____

Middle Name/s: _____ Date of Birth: _____ /____/_____

Residential Address: _____

Postal Address: _____

Phone: (H) _____ (W) _____ (M) _____

Receive SMS: Yes No Email Address: _____

Next of Kin (NOK) Name: _____Relationship: _____

NOK Contact Details: (H) _____ (W) _____ (M) _____ Do you consent to Dr Ahmed, or staff contacting your NOK about your medical history? Yes No

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Your Ref: _____ Expiry: _____ /_____

Patient Consent: Do you consent to Dr Ahmed to perform Gynaecological and / or Obstetrical examination, if required for your medical condition Yes No

Do you have an Aged Pension Card? Yes No Number: _____

Do you have Private Health Insurance? Yes No

Does your Private Health Insurer cover you for Obstetrics? Yes No

If Yes, which fund? _____ Membership No: _____

Referring Doctor's name: _____ Referral date: ____/_____/_____

Name of Clinic _____ Phone No: _____

Clinic Address: _____

Details of General Practitioner (if different from referring Doctor):

Doctor's Name: _____

Clinic Name: _____ Phone Number: _____

Address: _____

This is not a bulk billing practice. Accounts need to be settled on the day.

Please sign below to indicate you have understood the above and the details given on this form are correct at time of signing.

Signature: _____Date: _____/_____/