

Dr Gabriella Unsen
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Provider No 0105649H

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PATIENT REGISTRATION FORM

TITLE**DOB**...../...../.....

SURNAME:

GIVEN NAMES:

ADDRESS:

SUBURB:

TEL: (Home).....(Work).....(.Mob)

EMAIL:

MEDICARE Number: _ _ _ _ _ **Patient ID:** ____ **Exp Date** ____/____

PENSION / VET AFFAIRS Number

HEALTH FUND**MEMBERSHIP NUMBER**.....

Does your insurance cover you for Private Hospital Admission?

NOK.....Tel.

REFERRING DOCTOR: Name and Address

.....

Family Doctor (if different to referring doctor).....

.....

Will this be an insurance or workers compensation claim? Yes / No

Details:

PRIVACY STATEMENT

To comply with the Privacy Act 2001, all patients need to provide written consent for the following aspects of their medical care:

- I agree that Dr Unsen 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 and hospitals as necessary.
- I agree that Dr Unsen may discuss my medical history, diagnosis and management with my GP and other relevant specialists in relation to my medical management.
- I understand that I may apply to access my health records.

PATIENT NAME

PATIENT SIGNATURE.....**DATE**.....