PATIENT REGISTRATION & MEDICAL HISTORY FORM

Patient Details:					
Name					
Address					
Date of Birth		Home Phone No.:			
Mobile Phone No.:		Work Phone No:			
Appointment reminder:					
DVA/Pens Card Number		DVA Card Colour/Exp.			
Medicare Number		Expiry Date		Ref. Number	
Name of Private Health Fund		Membership Number			
GP Details					
Name					
Address					
Telephone Number		Fax Number			
Emergency Contact Details:					
Name					
Home Phone Number		Mobile Phone Number			
Relationship to patient					
Are you currently seeing any other Specialists?					
Name:					
Speciality:					
Phone & Fax:					
Address:					
List of current and past medical problems:					

Echo Heart Centre will use your personal information for the purpose for which it is submitted as per our Privacy Policy and Notice http://echoheartcentre.com.au

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List of current Medication(s):			
Family History:			
Are there any hereditary health diseases? (please select)			
If yes, please name them:			
Do you have diabetes? (please select)			
Diet Controlled ? (please select)			
Do you have any allergies? (please select)			
If yes, please name them:			
Are you a smoker? (please select)			
How long have you been smoking?		How many cigarettes do you smoke per day?	
How many standard alcoholic drinks do you consume per week?			

Healthcare Authorisation:

I hereby give my consent to Echo Heart Centre and/or Dr Steve Marasovic to provide medical treatment (cardiac diagnostic and therapeutic treatment) as may be deemed necessary.

Signed……Dated……

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Please email this form to admin@echoheartcentre.com.au or fax to 03 9217 6333