

Dr Smita Agarwal
MBBS, MS, FRANZCO
Ophthalmic Surgeon
45 Bridge Road, NOWRA, NSW 2541

Patient Registration Form

Title: Mr Mrs Miss Ms Mstr Dr (please circle one) Other: (please specify)
Surname:
First Name: Middle Name:
Date of Birth: Sex: M / F
Address:
..... Post Code:.....
Phone: Home: Work: Mobile:
Emergency Contact Person: Phone:
Medicare No: Ref No:..... Expiry Date:.....
Veteran's Affairs No: Gold/White/ (please specify)
Eligibility Conditions: (if any)
HCC/ Pension No: Expiry Date:
Referring Health Professional: Referral Date:
Family Doctor:
Private Health Fund: Y / N AMA HCF MBF MBP NAVY NIB TEACHERS WESTFUND
Other: Fund No:

Acknowledgment & Consent

I hereby authorise Dr Smita Agarwal and her nominees to:

1. record my personal information and take notes relevant to the reasons of my attendance;
2. organise diagnostic tests that Dr Smita Agarwal may deem fit. I acknowledge that such requests to third parties will include my personal information;
3. organise advice from other consultants and specialists. I acknowledge that the referrals for such advice will include my personal information, details of my medical condition and may include my diagnostic reports. I authorise Dr Smita Agarwal to retain the resulting reports;
4. correspond, request my medical records, other relevant documents and information on my behalf from any relevant hospital, medical practice, medical practitioner (including specialist) and allied health professional;
5. provide details of my relevant medical information on request to any relevant hospital, medical practice, medical practitioner, allied health professional, insurance company, or legal practitioner on receipt of an authority signed by me or on my behalf; and
6. send a letter to my referring medical professional.

Signature: Date:

Name: