

PATIENT REGISTRATION

VERSION FEBRUARY 2010

File No.: _____

Dr Raf Ghabrial

MB BS (Syd.Hons), FRANZCO

Ophthalmic Surgeon.
Orbital, Oculoplastic and
Cosmetic Surgery

DATE: | | | | | | | | | |

TITLE: _____ SURNAME: _____ FIRST NAME: _____

DOB: | | | | | | | | | |

ADDRESS: _____ POST CODE: | | | | | |

PHONE: (H) | | | | | | | | | |

(W) | | | | | | | | | |

(M) | | | | | | | | | |

EMAIL: _____

HEALTH FUND NAME OR UNINSURED: _____

MEMBER NUMBER: _____

MEDICARE NO: | | | | | | | | | |

MEDICARE REF NO: | | | | | | | | | | EXPIRY: | | | | | |

PENSIONER: YES NO

PENSIONER ID NUMBER: | | | | | | | | | |

EXPIRY: | | | | | | | | | |

DEPT OF VETERAN AFFAIRS NUMBER: | | | | | | | | | |

DVA EXPIRY: | | | | | | | | | |

GOLD CARD WHITE CARD

DVA TRANSPORT REQUIRED: YES NO

ALLERGIES: _____

MEDICATION: _____

HERBAL/HOMEOPATHIC MEDICATION: _____

DIABETES: YES NO

INSULIN: YES NO

GP NAME: _____

ADDRESS: _____ PHONE: | | | | | | | | | |

IN CASE OF EMERGENCY CONTACT: _____

PHONE: | | | | | | | | | |

RELATIONSHIP TO PATIENT: _____

WORKCOVER/THIRD PARTY CLAIMS

NAME OF INSURER/THIRD PARTY: _____

CLAIM NUMBER: _____

CLAIMS MANAGER: _____ PHONE: | | | | | | | | | |