DR BHAUMIK SHAH
MBBS MD FRACP
MEDICAL ONCOLOGIST
Also consulting at: St Vincent's Private Hospital Werribee
Moreland Orthopaedics and Specialists, Coburg

AURORA SPECIALISTS

NEW PATIENT REGISTRATION

Your details

Title (Circle): Mr/Miss/Mrs/Ms

First Name:	Surname:	
Date of Birth:	Age:	Gender (Circle): Male/Female

Occupation:

Your contact details

Home Address:

Suburb:	State:	Postcode:
Ph.(Mobile):	Ph.(Home):	Ph.(W)

E-mail:

Emergency contact details

Name:	Relationship To You:

Ph.(Mobile/Home):

Your Health Fund Details

Are you a Medicare card holder? Please circle: YES/NO

Medicare No.:	Reference No.:

Do you have Private Health Insurance? Please circle: YES/NO

Health Fund Name:	Member No.:

Do you have Pension Card? Please circle: YES/NO

Card Number:	Expiry Date:

Is this illness through Workcover? Please circle: YES/NO

Insurance Name:	Claim No.:

Are you covered by Department Veteran Affairs? Please circle: YES/NO

DVA No.:

Referral Details

Name of the Doctor who referred you:

Referred Doctor clinic address:

	Ph.:

Name of your usual GP:

GP Clinic Address:

	Ph.:

Please give details if any other Specialists/Doctors involved in your care:

_____

Suite 4, Level 6, 55 Victoria Parade
Fitzroy Victoria 3065

T 03 9416 0003
F 03 9417 0009

E reception@auroraspecialists.com.au
W www.auroraspecialists.com.au

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Medical History

Do you have any known allergies? Please circle: YES/NO
If Yes, please provide details here_____

Do you have any significant past medical history (Illnesses/Surgeries)? Please circle: YES/NO
If Yes, please provide details here _____
_____
_____

Do you have significant family history of cancers or major health issues (parents, siblings, children)? Please circle: YES/ NO
If Yes, please provide details here _____

Did you have any falls in last 6 months? Please circle: YES/ NO

Do you have any issues with memory, hearing or vision? Please circle: YES/ NO

Please list your current medications:
_____
_____

Social History

Who lives with you? _____

Who is your major support when you are unwell?
_____

Smoking History	Alcohol
Please circle: Never/Ex-smoker/Current	Please circle: Non-drinker/Light/Moderate/Heavy
How many cigarettes in a day? _____	No. of drinks each time _____

Anthropometry

Height (cm): _____	Weight (Kg): _____

Have you lost any weight in past? Please circle: YES/NO
If Yes, please provide details here_____

Patient's Consent:

☐ I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

☐ I understand that it is my responsibility to organise appointments to discuss test results with doctor. I understand that this practice doesn't give results over the phone or email in any circumstances.

☐ I understand that this is a private billing practice and services offered by doctors may incur charges. I am solely responsible to ensure the invoices issued by the practice are paid.

Patient's signature:_____ Date: _____

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