Dr Howard Zeimer
ENDOCRINOLOGIST
Diabetes - Thyroid - Bone disease
MBBS FRACP

Patient Registration – Please complete in block letters

(Please circle) Mr / Mrs / Master / Miss / Ms / Dr / Prof / Other

Surname: _____

Given Name: _____

Preferred Name: _____

Date of Birth: _____/_____/_____

Address:

_____

_____

Email _____

Telephone Numbers:

Home: _____**Work:** _____

Mobile: _____

Next of kin details (family member or friend)

Name: _____

Relationship to you:

_____

Contact number: _____

Medicare Number:_____

Ref No: (next to your name) _____

Exp Date: ____/_____/_____

Private Health Insurance (Hospital Cover): Yes / No

Private Health Fund Name: _____

Membership Number: _____

Concession Cards:

Aged or Disability Pension No: _____

Exp Date: ____/_____/_____

Dept. Veterans Affairs Card No: _____

White / Gold Exp Date: _____/____/_____

Health Care Card No: _____

Exp Date: ____/_____/____

Referring Doctor:

Name:

_____

Address:

_____

Date of Referral: _____/_____/_____

Are you allergic to any medicines, tapes or latex: Yes / No

If yes, please specify:

_____

_____

Patient Consent

Additional medication information may be required from other health professionals or health services used in the past. Obtaining this information may be beneficial to your medical management. I consent to Dr Zeimer accessing medical information, which is relevant to my management, from other doctors and diagnostic centres (e.g. pathology and radiology facilities.)

Yes / No

_____ _____

(signature) (print name)

Date _____/____/_____