DR CHRISTOS APOSTOLOU

Upper Gastrointestinal, Pancreatic & General Surgeon

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

TITLE:	MR ☐ MRS ☐ MS ☐ MISS ☐ MAST ☐ OTHER ☐			
SURNAME:				
GIVEN NAMES:			MALE: ☐ FEMALE: ☐	
ADDRESS:				
			POSTCODE:	
DATE OF BIRTH:			AGE:	
TELEPHONE NUMBERS:	(M)	(H)	(W)	
EMAIL:				
OCCUPATION:				
NEXT OF KIN:				
TELEPHONE NUMBERS:	(M)	(H)	(W)	
REFERRING DOCTOR:				
USUAL GP & SUBURB:				
MEDICARE NUMBER:				
	YOUR PLACE ON CARD:	EXPIRY DATE:		
PENSION NUMBER:		EXPIRY DATE:		
VETERANS AFFAIRS NO:		GOLD: ☐	WHITE: ☐	
PRIVATE HEALTH FUND:		MEMBERSHIP NUMBER:		

PERSONAL HEALTH INFORMATION

ALCOHOL:	YES ☐	NO ☐	SEVERAL TIMES A WEEK ☐	DAILY ☐
SMOKING:	YES ☐	NO ☐	SEVERAL PER WEEK ☐	DAILY ☐
MEDICATIONS:				
ALLERGIES:				
ARE YOU TAKING ASPIRIN OR BLOOD THINNERS?	YES: ☐	NO: ☐	REASON:	

FEES

This is a private practice and we do not bulk bill. The fees charged by this practice are generally on par as recommended by the Australian Medical Association and are payable at the time of consultation. We will endeavour to provide you with informed financial estimation prior to any planned procedure but this may not always be possible in emergency cases. Please feel free to enquire regarding costs at any stage of your care.

The following payment methods are available: Cash, Cheque, EFTPOS (Visa, MasterCard or Debit Cards)

PRIVACY NOTE

I agree to allow the doctors and staff at this practice to access all relevant information regarding my medical conditions. I agree that the doctors and staff may be required to forward/obtain information about my medical condition/history from my referring doctor or other health care providers. I understand that my clinical records may be accessed or reviewed by staff at this practice.

CONSENT

Clinical photographs will be taken as part of my consultation and my clinical photographs may be used for medical educational purposes (doctors/nurses/medical students only). Details of my consultation can be used in communication with other health care professionals who are involved in my care. Additionally, I give my permission for my clinical photographs to be used for public education purposes.

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION I HAVE PROVIDED ON THIS FORM IS ACCURATE

SIGNATURE:	**DATE:**
IF SIGNED BY A PARENT/GUARDIAN PLEASE COMPLETE:	
PARENT/GUARDIAN NAME: (PLEASE PRINT)	**TELEPHONE:**