VOSC
Mr Adam Skidmore

Patient Registration Form

Patient Details

Title: _____ Surname: ____________________ Given name:________________________________
Address: ____
Suburb: ________________________________ Postcode: _ _ _ _
DOB: ___ / ___ / ________
Mobile: _ _ _ _ _ _ _ _ _ _ Home Phone: _ _ _ _ _ _ _ _ _ _
Email: _________________________________ Work Phone: _ _ _ _ _ _ _ _ _ _
Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Patient Ref No: _ Expiry: _ _ / _ _ _ _
DVA: **Gold / White** Number: __________________________________
Hospital Fund: ___________________________ Membership Number: _______________________
Length of membership: ______________________
Work Cover/TAC Claim: **Yes / No** Details: ___________________________________
Next of Kin: Surname: ____________________ Given Name:________________________________
Contact number: _________________________ Relationship: ______________________________

Medical History

Please Tick All Relevant

☐ Reflux or Heartburn
☐ High Blood Pressure
☐ Type 1 Diabetes
☐ Type 2 Diabetes **Medication / Insulin / Both (circle relevant)**
☐ Heart Disease **Details:**
☐ Respiratory / Breathing Problems **Details:**
☐ Sleep Apnoea **If yes, do you use a CPAP machine?**
☐ Smoker **Past or Present:**
☐ Other Illnesses **Please Specify:**

☐ Previous Bariatric Surgery **Details (Including Surgeon if not Mr Skidmore):**

☐ Other Previous Surgeries

☐ Blood thinning medications **Please Specify:**

☐ Other medications (including herbal & over the counter) **Please Specify:**

☐ Any allergies including drugs, dressings or food **Please Specify:**

Office Use Only:

Height:	Weight: