REGISTRATION FORM

SHARMILA BALANATHAN

Vascular, Endovascular & Transplant Surgeon

MBCHB, FRACS

PERSONAL DETAILS

Surname		☐ Ms ☐ Miss
First name		☐ Mrs ☐ Mr
Date of birth	Occupation	
Home address		
Postal address		
Phone	Mobile	
Email		
Medicare number	Expiry	Ref
Health care/ pension number	Expiry	
Private health fund	Number	Level
DVA number	Colour	

LOCAL & REFERRING DOCTORS

GP name	Phone
Address	
Referring Doctor	Phone
Address	

NEXT OF KIN (NOK) / EMERGENCY CONTACT

Name	Relationship
Address	Phone

I provide my permission for my NOK above to enquire or speak on my behalf ☐ Agree Initial .....

YOUR HISTORY

Height: Weight:			*Please answer the following and if yes, provide further details*
Do you have any Allergies?	☐ yes	☐ no	
Do you smoke?	☐ yes	☐ no	☐ ex-smoker
Do you drink alcohol?	☐ yes	☐ no	
Do you take recreational drugs?	☐ yes	☐ no	
Females: could you be pregnant?	☐ yes	☐ no	

This form is continued overleaf ⟶

YOUR CURRENT AND PAST MEDICAL HISTORY

Please tick if you had or have any of the following and provide further details below.

☐ Diabetes	Heart disease:	☐ Respiratory disease
☐ High or low blood pressure	☐ Heart attack	☐ Asthma
☐ Blood transfusion	☐ Angina	☐ Kidney problems
☐ Cholesterol	☐ Palpitations	☐ Hiatus hernia/reflux/gastric ulcer
☐ Stroke/TIA	☐ Irregular heart beat	☐ Bowel problems
☐ Tendancy to bruise or bleed	☐ Heart murmur	☐ Sleep disorder/apnoea/snoring
☐ Anaemia	☐ Atrial fibrillation	☐ Epilepsy/fits
☐ Blood disorder	☐ Pacemaker	☐ Depression/other mental illness
☐ Blood clot in legs/lungs	☐ Heart surgery	☐ Dementia/Alzheimer's/Parkinson's

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Do you have: ☐ Advanced Care Directive ☐ An enduring power of attorney ☐ Health & medical guardian

SB Vascular is a private practice and payment on the day of appointment is required. A receipt will be issued to you upon finalisation of your invoice and can be submitted to Medicare on your behalf; or you may be required to attend a Medicare office to obtain your rebate. For some procedures in the rooms a deposit will be required with payment of the balance made when the final bill is issued. It is not the policy of this practice to bulk bill for services rendered. If you are having financial difficulties please discuss this with our rooms prior to your appointment. **I agree to pay all fees owing to SB Vascular at the time of my appointment and I acknowledge that I may be liable for costs associated with the recovery of any outstanding unpaid invoices.** I have read and agree with the SB Vascular Privacy Policy.

Signed ..... Date .....