Dr Sameer Jatkar

MBBS (Hons) BA MSc MPH MRMed
MClinEmbryol FRANZCOG

FERTILITY SPECIALIST • OBSTETRICIAN • GYNAECOLOGIST

Patient Registration Form

First name:

Surname:

Date of birth (DD/MM/YYYY):

Mobile number:

Telephone number:

Address:

Suburb:

Postcode:

Email address:

Occupation:

Medicare number:

Reference number:

Valid to (MM/YYYY):

Private Health Fund (please tick): ☐ Yes ☐ No

Fund name and member number (if applicable):

Please tick what you are seeing Dr Jatkar for:

☐ Gynaecology ☐ Infertility ☐ Pregnancy care

Have you had any previous pregnancies?

Partner's name (if applicable):

Date of birth (DD/MM/YYYY):

Mobile number:

Home phone number:

Medicare number:

Reference number:

Valid to (MM/YYYY):

Next of kin:

☐ Same as above (please tick)

Relationship to you:

Telephone number:

drjatkar.com.au

T: 03 8060 4275 **F:** 03 8414 4056 **E:** admin@drjatkar.com.au

East Melbourne
Suite 106, 320 Victoria Pde
East Melbourne, VIC 3002

Clayton
245 Clayton Rd
Clayton, VIC 3168

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Medical Information

Do you have any allergies? E.g. Medication, tapes, anaesthetics etc. (Please tick) ☐ Yes ☐ No

If yes, please specify:

Please tick if you have ever had any of the following:

- ☐ High blood pressure
- ☐ Angina
- ☐ Kidney Disease
- ☐ Blood clots in legs
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Heart attack
- ☐ Asthma
- ☐ Epilepsy or fits
- ☐ Blood clots in lungs
- ☐ Diabetes

Other health problems, please specify:

How did you hear about us?

Patient consent

I understand that the above (and/or any updated) information may be shared with my health providers, in accordance with the act 2/2001 of the health records act 2001.

I also understand that my pathology may be reviewed by other practitioners if Dr Jatkar onsiders it beneficial to my care.

I acknowledge that i am being seen as a private patient and understand that fees/charges will apply. I further understand that this practice does not bulk bill.

I acknowledge that i may be asked to undergo further testing, including pathology and ultrasound screening, for the purposes of determining my best course of treatment.

Signature:

Date (DD/MM/YYYY):

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