BBIVF

Registration Form

PATIENT DETAILS

SURNAME: _____ FIRST NAME: _____

MAIDEN NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

MAILING ADDRESS (IF DIFFERENT): _____

HOME PHONE: _____ WORK PHONE: _____

MOBILE PHONE: _____ EMAIL: _____

OCCUPATION:_____ SKYPE ADDRESS: _____

MEDICARE NUMBER: ☐☐☐☐ ☐☐☐☐☐ ☐ REFERENCE NO: VALID TO: /

HCC/ PENSION NO. ☐☐☐ - ☐☐☐ - ☐☐☐☐ EXPIRY DATE: / /

PRIVATE HEALTH FUND: _____ MEMBERSHIP NO: _____

PARTNER DETAILS ☐or NEXT OF KIN ☐ RELATIONSHIP TO YOU: _____

SURNAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ MOBILE: _____

MEDICARE NUMBER: ☐☐☐☐ ☐☐☐☐☐ ☐ REFERENCE NO: ☐ VALID TO: ☐☐ / ☐☐☐☐

PRIVATE HEALTH FUND: _____ MEMBERSHIP NO: _____

Please be aware that BBIVF administration may take a photograph of patients for inclusion in medical notes for identification purposes. Patients should also carry photo ID (including photo and signature) at all times as this will be required in the event that consent forms are signed in the clinic (consent forms signed outside of the clinic will need to be notarised).

HOW DID YOU HEAR ABOUT US: GP ☐ Friend ☐

Other Website _____ Advertisement -details/publication _____

ULTRASOUND EXAMINATION - As part of your consultation/investigations it may be necessary for your doctor to perform a transvaginal ultrasound. I hereby give permission for this investigation to be undertaken.

PATIENT SIGNATURE _____ **DATE** _____

PATIENT PROPERTY - Patients are reminded that valuables should not be brought into the clinic unless absolutely necessary. Personal property that is brought into the clinic is the responsibility of the patient and should be kept with the patient at all times.

PATIENT _____ **DATE** _____

PRIVACY POLICY

The privacy policy of this practice informs you that in the interest of your health care we need your consent to collect health and personal information from you. This information will be used by this practice for your health treatment and for administrative purposes and as such it may be necessary for us to exchange or disclose this information with others involved in your broader health care. If you have any concerns regarding our handling of your information please discuss this with myself or my secretaries.

I have read the above information and give my consent.

SIGNATURE OF PATIENT/S: _____ DATE: _____

SIGNATURE OF WITNESS: _____ DATE: _____

OFFICE USE ONLY

PATIENT PHOTO IDENTIFICATION SIGHTED AND COPIED ☐

DRIVERS LICENCE ☐ **/ PASSPORT** ☐ **/ OTHER PHOTO ID** ☐

STAFF SIGNATURE:.....

DATE:...../...../.....

BBIVF

p: 3606 3134

e: reception@bulkbillivf.com.au

w: www.bulkbillivf.com.au

ONLY COMPLETE THESE DETAILS IF YOU ARE UNDERGOING FERTILITY TREATMENT

PATIENT MEDICAL HISTORY:

ALLERGIES: _____

HEIGHT: _____ WEIGHT: _____

FEMALE FERTILITY HISTORY: (Please indicate cause of infertility if known):

UNEXPLAINED INFERTILITY: YES ☐ NO ☐

TUBAL: Sterilisation / Pelvic Inflammatory Disease / Previous Ectopic Pregnancy / Removal of Tube/s / Congenital Tubal Defect / Blocked Tubes

ENDOMETRIOSIS: Mild ☐ Moderate ☐ Severe ☐

OTHER _____

MALE FERTILITY HISTORY (Please indicate cause of infertility if known):

UNEXPLAINED INFERTILITY: YES ☐ NO ☐

Vasectomy (Sterilisation) / Unsuccessful Vasectomy reversal / No sperm (Azoospermia) / Low sperm count (Oligospermia) / Decreased sperm motility / Abnormal sperm morphology / Endocrine disorders.

OTHER _____

PREVIOUS FERTILITY TREATMENT HISTORY: YES / NO (Please circle)

WHERE: _____ WHEN: _____

PLEASE INDICATE NO. OF CYCLES:

INTRAUTERINE INSEMINATION (IUI) ☐

INVITRO FERTILISATION (IVF) ☐

FROZEN EMBRYO TRANSFER ☐

PREGNANCY HISTORY:

NUMBER OF PREGNANCIES	☐	NUMBER OF LIVE BIRTHS	☐	STILL BIRTHS	☐
MISCARRIAGES:	☐	(Please indicate gestation)	☐		
TERMINATIONS:	☐	(Please indicate gestation)	☐		
ECTOPICS:	☐	(Please indicate gestation)	☐		

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I have read and understood BBIVF's Privacy Policy. This Policy describes how BBIVF may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. If you would like a copy of the Privacy Policy for your records please ask at reception.

Signature of Patient_____ Date _____

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