

**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:...../...../.....

**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 \_\_\_\_\_