Mr. Daniel Steiner

MBBS (Hons), FRACS Urology

Urologist

Appointments & Correspondence via:
Suite 8.6, Level 8, Danks Wing
Epworth Hospital, 89 Bridge Road, Richmond 3121
Phone: Rooms 03 9421 3911 Fax 03 9421 3877

We prefer to send & receive letters via Argus

Pager: 03 9387 1000
Web: www.steinerurology.com.au
www.melbournekidneystoneclinic.com.au
Email: daniel@steinerurology.com.au
ABN: 26 177 358 924 Prov No: 253193AF

PATIENT REGISTRATION FORM

Title: Mr/ Mrs / Ms / Miss / Dr Date of Birth: .....

Surname: ..... First Name: .....

Preferred Name *(if different to above):* .....

Address: .....

Suburb: ..... Postcode: .....

Phone: (H) ..... (W) .....

Mobile: ..... Email: .....

Medicare No: ..... Ref no: .....

Health Insurance Fund: ..... Member No: .....
(write "Nil" if you DO NOT have Private Health Insurance or only have "Extras" cover)

Age Pension No: ..... Expiry: .....

DVA No: ..... Gold card / White card

GP name & clinic address: .....

.....

Please list any medication allergies: .....

How did you find out about our surgery?

☐ GP Recommendation ☐ Family/Friends ☐ Specialist Recommendation

☐ Healthshare ☐ Internet ☐ Other (please specify).....

PLEASE NOTE PAYMENT IS REQUIRED ON DAY OF CONSULTATION

REDUCED FEE FOR AGE PENSION CARD HOLDERS ONLY

PTO

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Patient Name: ..... DOB: .....

EMERGENCY DETAILS

Please only provide details of people you consent us to contact.
Your Next of Kin may be contacted after any procedures you have in hospital with Mr Steiner, or we may contact them in the event we are unable to contact you regarding your appointments, billing or test results. You may change this by writing to us any time.

Next of Kin: .....

Relationship to patient: .....

Contact Number: .....

Alternate Contact Person's Name: .....

Relationship to patient: .....

Contact Number: .....

By signing below, I agree that my contact details, Medicare/Insurance details and medical information may be forwarded to other doctors, hospitals and pathology/radiology companies involved in my care as deemed necessary by Mr Daniel Steiner and his staff, and to collect medical information as required from other doctors, hospitals and pathology/radiology companies.

....

Patient signature Date of consent

By not signing the above or completing the form in full, I understand that I may limit the practice's ability to provide me with a full service.
A copy of Power of Attorney paper should be provided where applicable.