Dr Charles H. C. Pilgrim, MBBS (Hons), FRACS, PhD
Hepatopancreaticobiliary Surgeon
Laparoscopic and Robotic Surgeon
Military and Trauma Surgeon
General Surgeon

FRACS Fellow of the Royal Australasian College of Surgeons

PATIENT REGISTRATION FORM

Please Note: This is not a bulk-billing practice. Fees are calculated from the Medicare Schedule and AMA (Australian Medical Association) recommendations. Fees are charged as follows:

	Dr Pilgrim's fee	Medicare Rebate
New Consultation (long):	$170.00	$72.75
First Consultation (short):	$120.00	$72.75
Review Consultation:	$100.00	$36.55

There will be a gap payment that you are responsible for, in addition to the Medicare rebate. If you do not accept these fees please notify the receptionist prior to your appointment.

PERSONAL INFORMATION *(please complete in BLOCK letters)*

Surname ..... Title .....

Given Names .....

Address .....

..... Postcode .....

Telephone (H) ..... (W) .....

(Mbl) .....

Date of Birth ..... Occupation .....

Contact in case of Emergency .....

Relationship ..... Phone Number .....

ACCOUNT INFORMATION

Medicare No. ...../...../...../...../...../...../...../...../...../..... Number beside name on Medicare Card ……

Expiry Date: ...../.....

Do you have Private Health Insurance: (please tick) ☐ no ☐ yes → Fund (eg HBA) ……

Membership Number ……

Are you covered by any of the following: ☐ Veterans Affairs ☐ Other eg TAC / Workcover

Entitlement Number ..... Expiry Date .....

FAMILY DOCTOR INFORMATION

Name of referring doctor .....

Address .....

.....

Name of family doctor / GP .....
(if same as referring doctor, write "as above")

Address .....

.....

The personal health information you provide during your consultation and subsequent treatment will be collected for the purpose of providing high quality health care. This clinic is committed to protecting your privacy and this information is generally only disclosed to other members of your treating team where necessary. It will however be disclosed to other organisations where required by law or if necessary for debt recovery purposes. **Should your account exceed our trading terms and be passed on for collection all additional costs will be the liability of the patient.** De-identified and anonymous health information is maintained as part of a clinical database for all patients in this practice for the purposes of research, education & quality assurance. Please check this box if you do not wish to be involved in this manner. ☐

Signature ..... Date .....

GENERAL MEDICAL INFORMATION

What is your height …… cms, or …… feet and inches

What is your weight …… kgs/stone (strikethrough the incorrect term)

Have you recently lost weight?

☐ no ☐ yes → how much weight have you lost? …… kg, in …… months

Have you previously undergone any type of surgery?

Surgery	Hospital	Year

Have you ever previously been in hospital for any other reason?

Diagnosis	Hospital	Year

Are you being seen by any medical or allied health specialists?

Name of practitioner	Speciality	Location seen

Current medications

Name	Dose	Frequency

Name (cont.)	Dose	Frequency

Are you allergic to anything?

☐ no ☐ yes → what are you allergic to? ……

→ what reaction do you have? ……

Are you a smoker?

☐ never smoked

☐ current smoker how many cigarettes/day? …… when did you start (year)? ……

☐ ex smoker date quit (month/year) …… previously how many cigarettes/day? ……

for how many years did you smoke? ……

How much alcohol do you consume each week? …… standard glasses wine/beer/spirits (circle applicable)

Do you have diabetes? ☐ no ☐ type 1 diabetes ☐ type 2 diabetes

Have you ever been treated with chemotherapy?

☐ no ☐ yes → date commenced (month/year) ……

→ date completed (month/year) ……

→ regimen name ……

Do any diseases run in the family, or is there any family history of illness?

Relationship to you (eg. your mother)	Illness	Age at onset