PATIENT REGISTRATION (Page 1 of 3)

ERRARD SPECIALIST PRACTICE

We ask for the following information for the purpose of maintaining accurate and complete Medical Records

TITLE: MR ☐ MRS ☐ MS ☐ MST ☐ MISS ☐ DR ☐

GENDER STATUS: _____ **OCCUPATION:** _____

FIRST NAME: _____ **SURNAME:** _____

KNOWN AS:_____ **Date of Birth:**_____/_____/_____

POSTAL ADDRESS:_____

SUBURB:_____ **STATE:**_____ **POSTCODE:**_____

HOME PHONE:_____ **WORK PHONE:**_____

MOBILE NO:_____**EMAIL:**_____

APPOINTMENT REMINDERS WILL BE SENT TO YOU VIA TEXT MESSAGE. PLEASE INFORM RECEPTION STAFF IF THIS IS UNSUITABLE

MEDICARE NUMBER: __ __ __ __ __ __ __ __ __ __ **REF:** __ ***(Number next to patient name on card)***

MEDICARE EXPIRY: __ __ / __ __ __ __

PRIVATE HEALTH FUND: _____ **MEMBERSHIP NO:**_____

LEVEL OF COVER (hospital/extras only): _____

Have you had your private health insurance for longer than 12 months: YES / NO

PENSION/HCC/CONCESSION NUMBER: _____

EXPIRY: __ __/__ __ /__ __ __ __

DVA NUMBER: _____ **COLOUR: GOLD / WHITE**

ABORIGINAL/TORRES STRAIGHT ISLANDER: YES/NO

REFERRING DOCTOR: _____ **Is this your usual GP? YES / NO**

IF NO, USUAL GP: _____ **CONTACT NO:** _____

ADDRESS: _____

EMERGENCY CONTACT:

NAME: _____ **CONTACT NO:** _____

RELATIONSHIP TO PATIENT: _____

PERSONAL RESPONSIBLE FOR PAYMENT OF ACCOUNT IF DIFFERENT FROM PATIENT:

ACCOUNT HOLDER <u>MUST BE</u> OVER THE AGE OF 18

TITLE: MR ☐ MRS ☐ MS ☐ MST ☐ MISS ☐ DR ☐

FIRST NAME: _____ **SURNAME:** _____

MIDDLE NAME: _____ **DATE OF BIRTH:** _____/ _____/ _____

MEDICARE NUMBER: __ __ __ __ __ __ __ __ __ __ **REF:** __ **EXP:** __ __ / __ __ __ __

THIRD PARTY ACCOUNT HOLDERS (Page 2 of 3)

If your appointment is the result of a work place or transport accident, written approval must be provided prior to your appointment or you, the patient, will be responsible for payment on the day.

TAC CLAIM: YES / NO

CLAIM NUMBER: _____ DATE OF INJURY: ____ / ____ / _____

CASE MANAGER: _____ CONTACT: _____

WORKCOVER CLAIM: YES / NO

CLAIM NUMBER: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

CONTACT: _____ DATE OF INJURY: ___ / ___ / ____

INJURY: _____

CAUSE OF INJURY: _____

_____

HEALTH INFORMATION

Would you please provide us with health information relevant to your appointment? This information will be gathered to ensure you get most out of the consultation. This information may also be used if you require surgical intervention.

Have you had any recent imaging (X-ray, CT, MRI, PET etc.), blood tests, hearing tests or other investigations relevant to your appointment in the last 12 months?

YES / NO

If yes,

DATE *Eg: April 2016*	**INVESTIGATION TYPE** *Blood Tests*	**PROVIDER** *Melb Pathology*	**LOCATION** *Ballarat*

Are you diabetic? YES / NO Height: _____cm Weight: _____kg

Are you on any blood thinning medications? YES / NO

If yes, please specify: _____

Do you have any allergies? YES / NO

If yes, please specify: _____

CONSENT FORM **(Page 3 of 3)**

Please read this information carefully and sign where indicated.

This Medical Practice collects information from you for the purpose of providing quality health care.

We require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

This means we will use the information you provide in the following ways:

- Administrative purposes in running our Medical Practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical test and in the report of results returned to us, following these referrals.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt-out' of any involvement.
- Disclosure to other doctors in this practice, locums and registrars attached to the practice, for the purpose of patient care and teaching.

Please let us know if you do not want your records accessed for these purposes and will note your records accordingly.

CONSENT

I have read the information above and understand the reasons why my information is to be collected.

I am also aware that this practice has a privacy policy that relates to the collection and storage of patient information.

I understand that I am not obliged to provide any information requested of me, but failure to do so might compromise the quality of the health care given to me.

I am aware of my right to access the information collected about me, except in some circumstances, where access may be legitimately withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access or disclosure that I notify this practice of.

SIGNED: $\mathcal{X}$**_____ NAME: _____ DATE: ___ / ___ / ___**

PERMISSION TO UPLOAD SPECIALIST LETTERS TO MY HEALTH RECORD: YES / NO