SCENT
SYDNEY CENTRE FOR EAR NOSE & THROAT

NEW PATIENT REGISTRATION FORM

Title eg. Mr/Mrs/Ms/Miss/Mast/Dr: Patient's Date of Birth:

Patient's Surname:

Patient Given Name(s):

Parent/Guardian name (if under 18):Mr/Mrs/Ms/Miss/Dr:

Parent Date of Birth: Ph (Mobile): Ph (Home):

Full Address:

Email Address:

Please TICK if you have a Pension Card or Veteran Affairs Card:
(and hand card to reception at your appointment for validation)

Medicare Number: _ _ _ _ _ _ _ _ _ _ Medicare Expiry Date:

Patient's Medicare Ref. Number: **Parent's** Medicare Ref Number if Patient Under 18:

Health Fund Details: (please tick here if not applicable)

Name of Health Fund:

Health Fund Membership Number: Health Fund Ref. Nbr:

Regular GP (if not the referring doctor):

Medical Practice Name:

Do you have any existing court orders related to the custody or care of your child?

Yes:

No:

If yes, please provide **reception** with a copy/most recent court orders.

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PRIVACY AND FINANCIAL CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below. Our privacy policy is available on our website.

This medical practice collects information from you for the primary 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. The means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.

2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3. 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 tests and in the reports or results returned to us following the referrals.

4. For Auditing and Research purposes.

PRIVACY AND FINANCIAL CONSENT

Please tick the boxes below to indicate that you have read and understood the privacy and financial information provided to you.

☐ I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

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

☐ I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be 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 purposes 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 limitations on access or disclosure of which I may notify this practice.

☐ I consent to the electronic transmission of my patient records to other medical providers and/or practitioners in relation to my health.

☐ I hereby agree to pay all financial charges arising from the medical consultation and associated services provided, on the day of the consultation.

Patients full name and date of consent;

If you have any queries, please do not hesitate to contact us.

Reception
Sydney Centre for Ear, Nose & Throat