PATIENT REGISTRATION FORM

Sydney Gastrointestinal Specialists

PATIENT DETAILS

Title:	Surname:	
First name:		Middle name:
Preferred name:	Gender: ☐ Male ☐ Female ☐ Other	Date of Birth:
Residential address: .... Postcode:		☐Single ☐Partnered, de facto ☐Minor ☐Separated, divorced ☐Married ☐Widowed
		Home phone:
Email:		Work phone:
Occupation:		Mobile phone:

MEDICARE, HEALH FUND AND CONCESSION CARD INFORMATION

Medicare number:	Ref no:	Expiry date:
Pension/HCC number:		Expiry date:
DVA number:	☐ Gold ☐ White	Expiry date:
Health fund:	Membership number:	Ref no:

NEXT OF KIN & EMERGENCY CONTACTS

Next of kin's name:	Phone:
Relationship:	Phone #2:
Address:	
Person to contact in emergency: ☐ Next of kin ☐ Other	Phone:
Name:	Relationship:

GP & OTHER MEDICAL PRACTITIONER CONTACT INFORMATION

Usual GP's name:	Phone:
GP address:	Fax:

Are there other medical practitioners you would like correspondence to also be sent to? If so, please list them:

Name & address:	Specialty:
	Phone:
Name & address:	Specialty:
	Phone:

CONSENT TO COLLECT & SHARE PATIENT INFORMATION

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 medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice
2. Billing purposes, including with Medicare and the Health Insurance Commission requirements
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice, as advised by you.

- I understand the reasons why my information must be collected.
- 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 be 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 purpose other than above, that my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out about, subject to any limitations on access or disclosure of which I may notify this practice.

Signature:	Name:	Date: