PATIENT REGISTRATION FORM - CASEY SURGICAL GROUP

Mr Mikhail Fisher / Mr Foong Loh / Mr Suren Jayaweera / Mr Eric Ee

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Mr / Mst / Mrs / Ms / Miss / Dr

SURNAME: ____

GIVEN NAMES: ____

PREFERRED NAME: ____

ADDRESS: ____

____ POSTCODE: ____ ____ ____ ____

DATE OF BIRTH: _____ / _____ / _________ MOBILE: ______________________________

EMAIL ADDRESS: ____

MEDICARE NUMBER: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

REFERENCE NUMBER BESIDE YOUR NAME: _____ VALID TO DATE: _____ / ______

PRIVATE HEALTH INSURANCE FUND: ____

PRIVATE HEALTH MEMBERSHIP NUMBER: ________________________ HOSPITAL OR EXTRAS (circle)

AGED PENSION NUMBER: _________________________________ EXPIRY DATE: _____ / _____ / _____

VETERANS AFFAIRS NUMBER: _______________________ CARD COLOUR: ________________

NEXT OF KIN NAME: ____

NEXT OF KIN PHONE: _________________________ RELATIONSHIP: ____________________________

USUAL GP NAME AND ADDRESS: ____

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

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. We will use the information you provide in the following ways.

* Administration purposed in running our medical practice.
* Billing purposes, including compliance with Medicare, Health Insurance Commission, WorkCover and Transport Accident Commission requirements.
* Disclosure to others involved in your health care, including treating doctors and other specialists outside this medical practice. This may occur through referral to other doctors or for medical investigations and in the reports of results returned to us following referrals. We will also send a report to your referring doctor.

I also give permission for medical information to be obtained from any other source in order to help with my treatment.

I have read the information above and understand 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 may compromise the quality of 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 of 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.

Name: __________________________ Signature:__________________________ Date:____ / ____ / ______