Mr Justin Lade
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Patient Registration Form

Title: Mr / Mrs / Miss / Ms / Mst / Dr Surname (Family name): ……..

First name: …….. Known as …….. ……..……

Address: ……..……

……..

Phone: (H): …… (W) : …….. (Mob): ……..……

Email address: ……..……..

Date of Birth: ……/……../…… Occupation: ……..……..

Next of Kin: ……..…… Relationship: ……..……..

Contact details: (H) …… (M): ……..……..

Referring Doctor: ……..…… Phone: ……

Address: ……..……..

Usual GP (Family Doctor)……..……..

……..……..

Medical Insurance information

Medicare No: ……..…… Ref on card: …….. Expiry: …….. / ……

Pension Card: ……..…… Veterans Affairs No: …… Gold Card: Yes / No

Private Health Fund: …….. Membership No: ……..……

TAC / Workcover: Claim No: …….. Date of injury: ……../ ……/ ……..

Insurance company: …….. Case Manager: ……..

Contact details: Address: ……

Phone: …… Fax: …… Email: ……

Employer: ……..…… Phone: ……

Contact details: Address: ……..……

Health Questionnaire

Do you smoke? Yes / No If so, how many per day ……

Do you have (please circle): Asthma Heart Disorders Respiratory Disorders Diabetes, Type 1 or II

Do you take any of the following medications (please circle):

Warfarin Clopidogrel Prednisolone Aspirin Methotrexate Insulin

Do you have any allergies? Yes / No If so, please list: ……..

Privacy Consent Agreement

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 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:

1. Administrative purposes in running our medical practice
2. Billing purposes, including compliance 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. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.

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 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 that I will be given an explanation in these circumstances.

I understand and consent for my information is to be used as set out above, my further consent will be obtained should my information be required for any other purposes, subject to any limitations on access or disclosure of which I may notify this practice.

I have read the above and agree to the above. I consent to all or any of the above information being released to other health providers and agencies should it be deemed necessary as part of my treatment.

Signature: …… Dated: ……/……../……..

Consent to participate in Research and / or to allow photography to be taken for clinical purposes:

I, …….. am willing to participate in the collection of data for research purposes (all data is de-identified). I am also happy for photographs to be taken of my condition for medical teaching / research purposes.

Signature: …… Dated: ……../……../ ……

Name: (please print) ……