

Patient Registration Form			
Full Legal Name:			
Preferred Name:		Title:	Gender:
Date of birth:		Occupation:	
Home Ph:	Work Ph:	Mobile:	
Email:			
Street:			
Suburb:	City:	Postcode:	

Medicare and Concession Cards

Medicare Card: ___ / ___ / ___	Ref No: ___	Expiry Date:
Pension/Health Care Card: _____	Expiry Date:	
DVA – Department of Veteran Affairs Card: _____		

Private Health Cover

Private Hospital Insurance Provider:	Membership Number:	
Basic	Intermediate	Top

Next of Kin / Emergency Contact Policy

Please provide details of your Next of Kin / Emergency contact. The nominated person will only be contacted for emergency purposes in the immediate health & safety interests of the patient.		
Contact:	Relationship:	Ph:

Payment Policy & Cancellation Policy

Payment is expected on day of consultation. Eftpos facilities are available, cash and cheques are also accepted.
Cancellations & Rescheduling: A minimum of 48 Hour notices is required for all cancellations. Failure do so may incur a fee.
For information regarding billing arrangements for associated services from allied health practitioners such as pathology and radiology, these details should be sought directly from the health provider providing these services.

General Information

How did you hear about us? Please select from the following options:				
GP	Specialist	Internet	Friend / Relative	Other
OFFICE USE ONLY				
Pracsoft	Med Director	Date:	Initial:	

Do you consent to SMS contact / reminders from this practice?	YES / NO
Do you consent to our rooms communicating with your next of kin/emergency contact for the purpose of confirming appointments?	YES / NO
<p>Transfer of Information Policy (To patient) Email / Post and Fax Transmissions</p> <p>We are able to send and receive documents electronically via email, fax and post upon your request or where you have provided your consent for us to do so. However as such transmissions are not secure, information may be copied, recorded, read or interfered with by third parties while in transit. If you ask us to send any document electronically or by post you release us from any claim you may have as a result of any unauthorised use of that document, for any delay or non-delivery of any document and for any damage caused to your system or files.</p> <p>Documents permitted:</p> <ul style="list-style-type: none"> • Appointment reminders • Pathology & Radiology request forms • Referrals • Results (after discussion with your doctor) • Medical Attendance Certificate <p>All requests regarding treatment decisions, changes to medication, results, treatment plans must be discussed with your doctor during your appointment.</p>	
Do you consent to our 'Transfer of Information Policy'? (Includes posting, faxing or emailing patient requests)	YES / NO

Privacy Policy

<p>We value the doctor-patient relationship. Patient privacy is vital to such a relationship. The Privacy Act 1988 and its recent amendments formalise the already existing and acknowledge privacy obligations of our practice. We are committed to dealing with your personal and medical information correctly.</p> <p>Our doctors and staff collect information from patients primarily to provide proper care and treatment. We have a legal and ethical duty to protect patient information. Patient information may have to be disclosed to other doctors, nurses, therapists and medical technicians so that proper health care is not compromised. In some situations, it may be necessary to contact you or your healthcare providers urgently via email, which may not be secure.</p> <p>Your information may be shared with other health providers from time to time. This may include referring doctors, pathology laboratories, radiology practices, or other healthcare providers. This will only be used for purposes related to your clinical care to communicate with other medical practitioners involved in your medical care.</p> <p>The doctors in this practice are members of various medical and professional bodies. These organisations provide valuable services to their members. They require members to provide information in relation to their medical practice, which may include patient information.</p> <p>If you have any questions about how we handle your personal health information or need to arrange access to your records, please ask the Practice Manager or your treating doctor. Our complete Privacy Policy is available on our website or a copy can be requested from the reception team.</p> <p><i>Visit our website for the complete Privacy Policy www.endomelb.com.au</i></p> <p>You can assist in maintaining the accuracy of your information by advising the practice of changes to your personal contact details.</p> <p>I _____ have read, understood & agree with the Next of Kin, Transfer of Information, Payment and Privacy Policies of this Practice.</p>	
Signature:	Date:
<p>To be completed by Associate Professor Elif Ekinci' patients only I understand that Associate Professor Elif Ekinci is consulting in her private capacity and independently of the University of Melbourne.</p>	
Signature:	Date: