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### Patient Registration & Consent Form

Ms Miss Mrs Mr Dr Prof <small>Please circle</small>	First Name:	Surname:
Street Address:		
Suburb:		Postcode:
Postal Address: <small>If different from above</small>		
Date of Birth: / /	Home Phone:	Mobile Phone:
Email Address:		Occupation:
Emergency Contact Name:		Relation:
Emergency Contact Phone Number:		
Usual GP Name: <small>(if different from referring doctor)</small>		

Medicare Card Number: _____ Ref: ____ Expiry: ____ / ____
Health Care Card/Pension Card/DVA Card Number: _____ Expiry: ____/____/____
<i>For gastroenterology patients only</i>
Private Health Insurance Fund Name: _____ Member No: _____
<i>If patient is under 18 or not responsible for the account, the following details are required for Medicare purposes</i>
Account Holder's Name: _____ Date of Birth: ____ / ____ / ____ Phone: _____
Medicare Card Number: _____ Ref: ____ Expiry: ____ / ____

### Privacy Consent

Federal Privacy Law requires that fully informed voluntary consent be obtained for the collection of health information. Your personal information and medical history is collected, documented, stored securely and may include photographic images of your skin. This information is used for the following purposes:

- to assess, diagnose, treat and be proactive in your healthcare needs;
- for administrative and billing purposes - including Medicare, Workcover and Health Insurance Commission requirements;
- disclosure to other healthcare providers involved in your care including treating doctors and specialists outside of this practice through referral to other doctors or for medical tests;
- retrieving medical history from your other health care providers.

I have read the information above and 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 may compromise my own healthcare and treatment.  
 I consent to the handling of my information as outlined above, subject to any limitations on access or disclosure of which I may notify this practice.  
 I understand that I may withdraw my consent at any time by notifying this practice in writing.

**I understand that consultations are not bulk-billed, not payable by private health insurance and are payable on the day of consultation. I understand that if there is a need for a procedure or treatment, there will be an additional fee payable for these and I will be made aware of out-of-pocket costs prior to my procedure.**

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_