Mr Tim Price BSc, MbChB, DLO, FRSC (ORL-HNS), FRACS
Consultant Otorhinolaryngologist and Head and Neck Surgeon

PATIENT REGISTRATION DETAILS

CONFIDENTIAL INFORMATION TO BE INCORPORATE INTO YOUR MEDICAL FILE

Title (Circle one) Dr/Mr/Mrs/Ms/Miss/Other_____ _____
Full Name

Home Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Postal Address (if different from above): _____

Suburb: _____ **State:** _____ **Postcode:** _____

Date of birth: _____ **Occupation:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____ **SMS OPTION: Y/N**

Email: _____

Medicare No: _____ **Reference on card:** ____ **Medicare Expiry:** _____

Private Health Fund: _____ **Membership No.**_____ **Hospital / Extras / Both (Circle one)**

Heath Care/Pension/DVA Card Number (Circle one): _____ **Expiry:** _____

Referring Doctor: _____ **Specialist/GP referral (Circle one)**

Usual GP Details (if different from above): Name: _____

Address: _____

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP?
If so, please list:

Name	**Address**	**Phone**

Work cover / TAC: Claim Number: _____

Employer: _____ **Phone:** _____

Address: _____ **Insurer:** _____ **Date of Injury:** _____

Emergency contact: _____ **Relationship to patient:** _____

Home Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Mobile: _____

IF CHILD UNDER 18, PLEASE PROVIDE ADULT/GUARDIAN'S DETAILS FOR ACCOUNT PURPOSES:
Title (Circle one) Dr/Mr/Mrs/Ms/Miss/Other_____ _____

Full Name

Date of birth: _____ Tel: _____

Medicare No: _____ Reference on card: ___ Medicare Expiry: _____

PLEASE READ CAREFULLY: CONSENT TO COLLECT 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 compliance with Medicare and 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 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 the above, my consent will be sought.
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Signature: _____ Date: _____

CONSULATIONS:

This practice does not bulk bill. A fully paid invoice can be submitted to Medicare for a rebate. Accounts must be settled on the day of consultation. Payment methods include: cash, cheque, EFTPOS or credit card.

Any fees for surgery will be discussed with Dr Tim Price during the consultation. Patients will receive a comprehensive quote detailing their out of pocket costs. Fees for surgery are payable in advance.