**Dr. Sanyogita Tara**
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# PATIENT REGISTRATION

**Title:** Miss / Ms / Mrs / Dr **Date:** ______/______/____________

**Name:** Given ________________________ Middle ____________________ Family ______________________

**Residential Address:** ____________________________________________________________

Suburb: ________________________ Post Code: ________________

**Postal Address (if not same as above):** ____________________________________________

Suburb: ________________________ Post Code: ________________

**Email Address:** ____________________________________________________________

**Telephone:** (H): ____________________ (W): ____________________ (M): ____________________

**Date of Birth:** ________/________/______________ **Age:** ____________________

**Occupation:** ____________________________________________________________

**Employer:** ____________________________________________ Ph: ____________________

**Spouse/Partner/Next of Kin:** ________________________________ Ph: ____________________

**Nearest relative not Living with you:** __________________________ Ph: ____________________

Relationship to you: ____________________________________________________

***NOTE:*** *This information is for contact purposes only and these details will not be released*

**Do you have Hospital Insurance?** YES / NO

**Health Fund:** ________________________________________ **Membership#** ____________________

**Have you had this Insurance for more than 12 months?** YES / NO

**Medicare No:** ______________________________ **Ref#** ________ Expiry: ______/______/____________

**Pension Card No:** ________________________________________ Expiry: ______/______/____________

**General Practitioner (GP):** Name & Address: ____________________________________________

____________________________________________________________ Ph: ____________________

**Other Treating Doctor:** Name & Address: ____________________________________________

____________________________________________________________ Ph: ____________________

**PAYMENT OF ACCOUNT IS EXPECTED AT CONCLUSION OF CONSULTATION**

- Practice policy is for payment on the day of consultation.
- If this account is not paid within 30 days, your account may be sent to Debt Collection and you will be required to bear the debt recovery costs. Should your account present you a genuine financial problem, please discuss this with your doctor's secretary.
- I acknowledge that my personal information may have to be disclosed to or collected for Government & Health Fund statistics or to other treating health professionals so that my health care is not compromised. It will however be disclosed to other organisations where required by law or if necessary, for debt recovery purposes.

I HAVE READ AND UNDERSTAND THE ABOVE: ________________________ ______/______/____________

Signature Date

**PLEASE READ AND COMPLETE OTHER SIDE**

# PRIVACY LEGISLATION CONSENT FORM

**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 ask for your personal email address to enable the practice to convey ONLY Normal results for investigations, directly to you.**

We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be pro-active in our health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare, 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 the referrals.
- Disclosure to other doctors in the practice, locums and students attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes and will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I have read the information and understand the reasons why my information must be collected. am also aware that this practice has a privacy policy on handling patient information (which is available on request).

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 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 limitations on access or disclosure that I notify this practice of.

Signed: ________________________________________________ (Patient)

Date: _________/_________/________________

Name: ________________________________________________ (Please Print)