Dr Emma Hiscutt
Dr Ola Niewiadomski
Dr Suresh Sivanesan
Dr Jason Tye-Din
Dr Emma Halmos

Ground Floor, Harley Medical Chambers
171 Victoria Parade
FITZROY VIC 3065
Phone: 03 8417 9900
Fax: 03 9415 1069
Email: sivanesanoffice@gmail.com

Patient Registration & Consent Form

Ms Miss Mrs Mr Dr Prof Please circle	Date of Birth: / /	
First Name:	Surname:	
Street Address:		
Suburb:	State:	Postcode:
Postal Address: If different from above		
Home Phone Number:		Do you consent to receiving SMS reminders? YES / NO Please circle
Mobile Phone Number:		
Email Address:		
Occupation:		
Emergency Contact Name:		Relation:
Emergency Contact Phone Number:		
Usual GP Name: (if different from referring doctor)		

Medicare Card Number:	Ref: (number next to your name)	Expiry: /
Do you have private health insurance: YES / NO		
Health Fund Name:		
Health Fund Member Number:		
Health Care Card/Pension Card Number:		Expiry: / /
DVA Card Number:		DVA White // DVA Gold Please circle

Do you have any allergies: YES / NO Please circle If yes, please specify:
Do you take Warfarin/Aspirin/Clopidogrel or any other blood thinning medication? YES / NO Please circle If yes, please specify:

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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 high quality healthcare.

We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare 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 Medical and Health Insurance Commission requirements;

3. 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;

4. Retrieving medical history from other health providers, including previous operation records, imaging and pathology reports and consultation notes;

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 might compromise the quality of the healthcare and treatment given to me.

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.

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.

Name:	
Signature:	Date: / /