Patient Registration Form

PLEASE PRINT
Title: Mr Mrs Miss Ms Ps Dr (Med) Dr (PhD) Other: _____

Surname: _____ Given Names: _____

Date of Birth: / / Occupation: _____

Home Address: _____
_____
_____ Postcode: _____

Mailing Address (if different from above):
_____
_____
_____ Postcode: _____

Home phone no.: _____ Mobile: _____ Work: _____
Email:_____

Next of Kin: _____ Relationship: _____ Tel: _____

Medicare No.: _ _ _ _ _ _ _ _ _ _ _ Individual Ref No. (single digit in front of name): _ Exp Date:_ _/_ _ _ _

Health Fund Name: _____ Membership No. _____

Is this a Workers Compensation Claim or Third Party Claim: Y / N (please circle)

Insurer: _____ Claim No.: _____

Case Manager: _____ Tel:_____Fax:_____

Pensioner: Y / N Type: Aged / Disability / Other Pension No.: _____ Exp:_____

Veteran Affairs: Y / N Type: Gold / White / Other Card No.: _____ Exp: _____

Usual GP Name: _____ GP Tel: _____
GP Practice and address: _____
_____
_____
_____

If your GP above was not the Referrer, please enter details of Referring Doctor below:

Name: _____
Address: _____ Tel: _____
_____
_____

If there are any other interested health Professionals you would like to receive a copy Dr Curtis' clinical reports, please enter details below:

_____ _____
_____ _____
_____ _____

MEDICAL HISTORY

The information requested below is fully confidential and will be used for the purpose of medical communication, record keeping and treatment planning only.

Name:_____

ALLERGIES:

Are you allergic to any medications or have you had any allergic reactions in the past?

_____ _____

_____ _____

CURRENT MEDICATIONS:

Please list your current medications (unless you have brought a list from your doctor).

_____ _____

_____ _____

_____ _____

_____ _____

Are you taking any of the following anticoagulant medications or any other blood thinners?

Aspirin, Cartia, Asasantin, Warfarin, Astarix Plavix, Pradaxa (Please circle) Other: _____

PAST SURGERIES:

Operation	Approx Date
_____	_____
_____	_____
_____	_____

MEDICAL CONDITIONS:

Diabetes	Yes / No	
Hypertension	Yes / No	
Coronary Heart Disease	Yes / No	
Heart Failure	Yes / No	
Arrhythmia (abnormal heartbeat)	Yes / No	
Stroke / Transient Ischaemic Attacks	Yes / No	
DVT / pulmonary embolus	Yes / No	
Do you smoke?	Yes / No	Cigarettes per day _____
Do you drink alcohol?	Yes / No	Social only / Heavy drinker

Any other medical conditions:

_____

_____

_____

FINANCIAL CONSENT

This practice is guided by AMA (Australian Medical Association) fee values and thus there are out-of-pocket costs for services rendered. A discount is offered for aged pensioners, but we do not bulk bill. Payment for consultation is required at the time of appointment. All fees are partially recoverable through Medicare. Each consultation is allocated an MBS (Medicare Benefit Schedule) item number which is dependent on the nature of the appointment, and the actual time and complexity of the consultation.

Workers Compensation, Third Party and International Insurance patients must provide their insurer details, claim numbers and case manager details, along with guarantee of payments prior to their appointment. If written guarantee of payment is not received by the time of the appointment, the patient will be responsible for payment of the consultation at the time of the appointment, at standard Workers Compensation rates.

If your treatment requires hospital admission, you may choose to be admitted as a private, public or self-insured patient. Private accounts for surgery are guided by AMA fee values for item numbers used in actual surgery. Therefore only estimates can be provided for likely out-of-pocket surgical costs. Final costs are dependent on actual surgery performed. Estimates do not include costs for ancillary services or additional hospital or prosthetic costs. Patients are encouraged to discuss fee estimates with their health fund providers to ensure adequate hospital and prosthetic cover. Our practice does not usually participate in no-gap arrangements with health funds.

I accept responsibility for my accounts and agree to the above financial conditions.

Signed by Account Holder: _____

Print Name: _____

Date: _____

Dr Jonathan Curtis
Suite 205, Level 2
156 Pacific Highway
Greenwich NSW 2065

PRIVACY CONSENT

To comply with the Privacy Act 2001, all patients need to provide written consent for the following important aspects of their medical care.

The 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 a full 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 Health Insurance Commission requirements.

3. Disclosure to others involved in your health care and / or medical claims. This may include treating doctors, specialists, allied health care personnel outside this medical practice and any third party that is involved with your care. This may occur through referral to other doctors, medical tests, reports or results returned to us following referral.

4. To conduct practice audit and medical research, in which case all data is analysed without identifying personal details. Audit and research are important ways of maintaining high standards of medical practice. Audit is a requirement of the Royal Australian College of Surgeons.

Please sign the following declaration:

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. The practice will not provide information regarding my medical condition, appointments etc to anyone, including family members, unless I have agreed to this in writing.

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 that I will be given an explanation in these circumstances.

Name : _____

Signature: _____ Date: _____

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