***Patient Details:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title** | Mr | Mrs | Ms | Miss | Dr |
| **Surname** |  |  |  | **Date of Birth** |  |
| **First Name** |  | **Middle Initial** |  |
| **Street Address** |  |
| **Suburb** |  | **Post Code** |  |
| **Home Phone** |  | **Work Phone** |  | **Mobile Phone** |  |
| **Email** |  |
| **Name & contact of regular GP (if not referring doctor)** |  |
| **Medicare No** |  | **Ref No** | **Expiry Date** |
| **DVA** | Gold / White | **Ref No** | **Expiry Date** |  |
| **Pension No.** |  | **Expiry Date** |  |
| **HCC No.** |  | **Expiry Date** |  |
| **Private Health****Fund**  |  | **Member No** |  |
| **Emergency Contact** **Name & Number** |  |
| **Name of adult on Medicare Card (if child is under 18)** |  | **Ref No**  | **Date of birth of Adult** |

**If we need to contact you what is your preferred method of contact and reminders:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Mobile phone (+ SMS) |  | Home/Work phone (+ Voicemail) |  | Email |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient / Parent Signature (if child under 18)** |  | **Date:** | **\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_** |

*I confirm there is no other information that I am aware of that would influence the medical treatment/advice to be provided.*

**If you require your medical records to be forwarded from another practice,**

**please ask the receptionist for the appropriate form.Privacy Statement, Communication & Patient Consent**

The Health Records and Information Privacy Act 2002 require medical practitioners to obtain consent from their patients to collect, use and disclose the patient’s personal information.

In accordance with the Privacy Act (1988), all information collected in this practice is treated as sensitive, ensuring your privacy and maintaining confidentiality at all times. We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.

Selected information may be disclosed to various other health services involved in supporting your health care management, (e.g. Pathology & Radiology)

We value your privacy. All information about you or your child, held in this practice, is kept in the strictest confidence.

**Please Note** – Due to privacy laws it is preferred that adults and over sixteens arrange their own appointments whenever possible. Results **cannot** be given to a third party except under special circumstances.

A copy of the Practice’s Privacy Policy is available at Reception.

**CONSENT**

**In accordance with the Privacy Legislation (*Privacy Act 2002*),**

**🞏 I consent to the use of my OR my child’s personal health information by ENT Care Sydney and other health providers involved in my medical treatment and health care.**

**🞏 I consent to the disclosure of my OR my child’s personal health information by ENT Care Sydney to other health providers directly or indirectly involved in my personal health care or medical treatment.**

**🞏 I consent to the collection, release of medical imaging and/or clinical photos (de-identified) of my OR my child’s personal health information by ENT Care Sydney for purposes of education, training and research.**

**🞏 I understand that as part of my OR my child’s health care, ENT Care Sydney will need to contact me to remind me of an appointment, provide results, give instructions or provide other information. I consent to ENT Care Sydney can contact me via Mobile, Home or Work Phone, SMS, Voicemail or Email.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient / Parent Signature** |  | **Date:** | **\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_** |