North West Hospital Cardiology – Patient Registration Form

☐ Mr ☐Mrs ☐Ms ☐ Dr ☐Miss ☐ Master *Please tick*	Surname:	First Name:	DOB: / /

Home Address:

Street:		
Suburb:		
Post Code:		
Home Phone: ☐		Work Phone: ☐
Mobile Phone: ☐		
Email Address:		
	Please tick which is your preferred method of contact ☑	

Fund Details

Private health fund Name:		Member Number:	
Medicare number:	☐☐☐☐ ☐☐☐☐☐ ☐	Reference: ☐	Expiry: ☐☐/☐☐
Veterans Affairs Number:		Expiry: ☐☐/☐☐	Gold/White:
Referring Doctor's Name:		Date of referral: ☐☐/☐☐/☐☐	
Usual GP Name:			
GP Address:			
GP Phone:		GP Fax:	
Concession Cardholder:	Type:	No:	Expiry:

Next of Kin:

Name:		Relationship to self:
Telephone:		

Due to Privacy Legislation, we require your consent to collect personal information. This practice collects your information in order to identify your medical record and provide an accurate, quality health service. This means we will use the information you provide in the following ways:

- *Administrative purposes in running a specialist medical practice; including pre-operative and post-operative calls using phone numbers and names you have provided to us, as well as hospital interaction for booking surgical or delivery services*
- *Billing purposes, including compliance with Medicare and Health Insurance Commission requirements*
- *Disclosure to others involved in your medical care, including treating doctors, specialists, hospital booking staff outside this practice. This may occur through referral to other doctors, surgery at hospitals, for medical tests and in the reports or results returned to us following the referrals.*
- *Your consent for us to collect copies of medical information, including investigations, discharge letters and reports from hospitals after admissions of yourself.*

I have read the information above and understood 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 health care and treatment provided to me. I am aware of my right to access the information collected about me, except in 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 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 purpose set out above, subject to any limitations on access or disclosure and I notify this practice as of:

Patient Signature: **Date:** / /