SAPPHIRE COAST DIGESTIVE DISEASES CENTRE

NEW PATIENT REGISTRATION

CONTACT INFORMATION

TITLE: FIRST NAME: LAST NAME:

PREFERRED NAME: D.O.B: / /

GENDER: MOBILE PHONE:

HOME PHONE: WORK PHONE:

EMAIL

ADDRESS

STREET:

SUBURB: POSTCODE:

HEALTH FUNDS & INSURANCE

MEDICARE NO: REF NO: EXPIRY DATE: / /

INSURED: HEALTH FUND:

FUND NUMBER: REF NO: EXPIRY DATE: / /

NAME ON CARD (FIRST NAME, LAST NAME):

DVA NO: DVA CARD TYPE: EXPIRY DATE: / /

NAME ON CARD (FIRST NAME, LAST NAME):

CONCESSION:

HEALTH CARE NO: EXPIRY DATE: / /

PENSION NO: EXPIRY DATE: / /

CONCESSION NO: EXPIRY DATE: / /

THIRD PARTY CLAIM

INSURER: INJURY:

CLAIM NUMBER: INJURED ON: / /

CASE MANAGER: PHONE:

FAX: EMAIL:

EMPLOYER

REFERRALS

REFERRING DOCTOR NAME

HEALTH TEAM MEMBERS

DOCTORS NAME

DOCTORS ADDRESS

DOCTORS SPECIALITY

EMERGENCY CONTACT

FIRST NAME | LAST NAME

MOBILE PHONE | RELATIONSHIP

☐ I consent that my results can be released and discussed with my emergency contact.

FEE POLICY & PRIVACY STATEMENT

Fee Policy: There is a consultation fee and this is payable on the day of consultation. Failure to attend/ missed appointments, without prior contact to the office will incur a fee. By signing this form, you are agreeing to the fee policy. Surgical fees are discussed only if surgeon has recommended a procedure.

Privacy Statement: This practice handles personal information in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act. I consent to the handling of my information by this practice for the purpose of providing quality health care, associated administrative and billing purposes, give permission for medical information to be obtained from any other source in order to help with my treatment. I also give permission for medical photography to be used for planning procedures and follow up. Use for teaching, audit research or publication would require additional consent to be obtained. We require you to provide us with your personal details and 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 Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

I have read the above fee policy and privacy statement. I consent to the taking and use of my medical records as described. I have viewed the fees and agree to pay the costs of consultations and any surgical procedures performed:

SIGNATURE | NAME | DATE

Dr Darryl Mackender
MBBS, FRACP, MPH & Tropical Medicine
Gastroenterology
Hepatology & Bariatric Medicine

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