ENT Clinics
EAR NOSE THROAT
HEAD AND NECK SPECIALISTS

PATIENT REGISTRAION FORM

Patient's Title: Mr / Master / Mrs / Ms / Miss/ Dr (***please circle)***

First Name: _____ **Surname:** _____

Address: _____ **Suburb:** _____

Postcode: _____ **Date of birth:** ____/____/_____ **Home phone:** _____

Work Phone: _____ **Mobile number:** _____

Email Address: _____**Occupation:** _____

Patient's Medicare Number: _____**Ref # (next to patients' name):** ____

Pension #_____ **Type of Pension:** _____

DVA #_____ **GOLD/WHITE/BRONZE CARD** (please circle)

Workcover/Garrison Details (if applicable):_____

Health Fund Name: _____**Membership number:** _____

Next of kin name: _____**NOK Contact phone:** _____

Next of kin's relationship to patient: _____

Date of birth of the patients' parent/guardian *(If patient is under 18 years old):* _____/_____/_____

Medicare # for parent/guardian: _____ **Ref #:**_____

Referral Information If you have a Medicare card you must provide us with a current doctor's referral in order to be eligible to claim the maximum rebate back from Medicare.

Name of your referring doctor: _____

Suburb: _____**Contact Number:** _____

Name of your GP ***(if different to your referring doctor):*** _____

Suburb: _____ **Contact number:** _____

Medications: Please list all medications you are currently taking: **If you are currently taking any naturopathic remedies, please list** (e.g. Garlic tablets, fish oil, vitamin E, St John's Wort etc.):

_____

_____

Any Allergies: _____

_____

Have you any of the following? (Please circle your answer)

Heart problems	Yes	No	High Blood Pressure	Yes	No
Diabetes 1 or 2	Yes	No	Hepatitis: A B C D E, HIV	Yes	No
Asthma	Yes	No	Radiation treatment	Yes	No
Liver or Kidney problems	Yes	No			

Ladies, are you pregnant? Yes No Due date ___/___/___ Breastfeeding: Yes No

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Other medical conditions and previous operations:

_____ _____

Financial Consent ***(Not required for patients pre-approved under Surgery Connect, Garrison, DVA and Workcover)***

Payment at the time of consultation is required. We accept EFTPOS, Cash, or Credit Cards. Unfortunately, we do not accept personal cheques, AMEX or Diners Card. **If the above information is correct, and you agree with our terms of payment, please sign below.**

Signed: _____**Date**: ____/____/____

COVID 19 – SCREENING DECLARATION

I declare that that I _____
I am not experiencing any symptoms of COVID-19 or Influenza ☐
I have not been in close contact with a confirmed COVID-19 case ☐
I am not, nor are any members of my immediate household, waiting for the results of a COVID-19 test
I have not been in a COIVD-19 declared hotspot identified area of concern within 14 days of your visit ☐ OR
If I have been in a COVID-19 hotspot or identified are of concern, I have undertaken a COVID-19 test within 72 hours of my appointment and received a negative result ☐

AUSTRALIAN PRIVACY PRINCIPLES (APP) POLICY 2014

COLLECTION AND USE OF PERSONAL INFORMATION

WE REQUIRE YOUR CONSENT TO COLLECT PERSONAL INFORMATION ABOUT YOU. PLEASE READ THIS INFORMATION CAREFULLY, AND SIGN WHERE INDICATED BELOW.

ENT Clinics follows the terms and conditions of privacy and confidentiality in accordance to the Australian Privacy Principles (**APPs**) as per schedule 1 of the *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth), forming part of the *Privacy Act 1988* ('the Act'). A copy of our Practice Privacy Policy is available to view upon request.

This information will in most circumstances be collected directly from you over the phone, via our new patient form and during face-to-face consultation. **In other instances, ENT Clinics may need to collect personal information about a patient from a third party source. This may include:**

- other Specialist's, GP's involved in your care
- relatives

This will only be conducted if the patient has provided consent for ENT Clinics to collect his/her information from a third party source; or, where it is not reasonable or practical for ENT Clinics to collect this information directly from said patient. This may include where:

- the patient's health is potentially at risk and his/her personal information is needed to provide them with emergency medical treatment.

I have read the above information and understand the requirements of ENT Clinics and myself in how to manage my personal information whilst attending ENT Clinics.

Signed: _____ **Date:** ____/____/____