Dr. Alice Chang BASc, MBBS, FRACS(Ortho)
Orthopaedic Surgeon

Patient Registration Form

PATIENT DETAILS **Mr / Mrs / Ms / Miss / Mstr / Dr**		
Surname:	Given Name:	
Date of Birth:	E-mail:	
Home Tel:	Work:	Mobile:
Address:	Suburb/Postal Code:	
Next of Kin:	Relationship:	Mobile:
Referring Doctor:	Tel:	
Referring Doctor Address:		
Family Doctor (if different from above):	Tel:	
Family Doctor Address:		
Physiotherapist	Tel:	
Physiotherapist Address:		
Podiatrist:	Tel:	
Podiatrist Address:		
Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No (next to pt name): __	Exp Date: __ __ / __ __ __ __	
Health Fund Name:	Membership No:	
Pension / HCC No:	Exp Date: __ __ / __ __ / __ __ __ __	
Veterans Affairs (DVA) No:		
If patient is under 18 Parent/Guardian Full Name:	Parent/Guardian Date of Birth:	
Patient/Guardian Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No: __	Exp Date: __ __ / __ __ __ __	
Workers Compensation / Third Party (If applicable)	Date of Injury: __ __ / __ __ / __ __ __ __	
Employer's Name:	Contact Name:	
Address:	Tel:	
Insurance Company:	Contact Name:	
Address	Tel:	Claim No:

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CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This 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 full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare Australia requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Research and audit. This practice collects clinical information for the purpose of reviewing the results of both operative and non-operative treatments of various disease and injuries. The information is used to monitor and improve treatments and is part of the requirements for maintenance of specialist qualifications.

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.

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 I will be given an explanation in these circumstances.

I understand that if my information is to be 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 purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed: _____ Date: _____

Patient Name:_____

I have read the CONSENT FORM regarding the handling of my information by this practice for the purposes set out in this form. I consent to the handling of that information subject to any limitations on access or disclosure that I notify this practice of.