PATIENT REGISTRATION FORM

SURNAME:

GIVEN NAMES:

Title: (please circle) ◉ Mr ○ Mrs ○ Miss ○ M/s ○ Dr

Date of Birth:

Address:

Home Phone Number: **Work Phone Number:**

Mobile Phone Number:

REFERRING DOCTOR

Name: Date of Referral:

GP (if different to referring doctor)

HEALTH COVER DETAILS

Name of Health Fund:

Health Fund Membership No:

Medicare Care Number: __ __ __ __ __ __ __ __ __ __ **Expiry Date:** **ID #:**

Pension No:

Dept Veterans' Affairs No:

If your DVA card is white, what are you specifically covered for by Veterans' Affairs?

Peninsula Respiratory Group routinely remind patients via telephone or SMS messaging of their up coming appointments within the Group. Do you consent to this contact? Yes or No

Patient Signature: _____

I understand that payment is required on the day of consultation or testing and all outstanding accounts owed to the Practice or the Respiratory Laboratory will be paid by me prior to leaving this office.

Signature of person responsible for account **Date**

Patients **UNDER THE AGE OF 16 YEARS** please include parent's or guardian's details below:

SURNAME: GIVEN NAMES:

Address:

Relationship to Patient: Mobile Phone number:

Home Phone number: Work Phone number:

NB: Parent/s / Guardian will be responsible for all accounts incurred

PENINSULA PULMONARY
FUNCTION LABORATORY

Peninsula Respiratory Group acknowledges our obligations to you under the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988. Peninsula Respiratory Group Privacy Policy (Information Handling Procedures) is available on request.

12/10/21

Part A - Disclosure
Personal information we collect from you will be used primarily to assist us to provide you with optimal medical care. This also means that results from tests may be forwarded to health professionals and / or hospitals who are involved in your current or future care.

GENERAL CONSENT
FOR THE DISCLOSURE OF
PERSONAL / MEDICAL INFORMATION

Provided that Peninsula Respiratory Group and staff do their best to maintain the confidentiality of my medical record, I hereby consent to the disclosure of my personal / medical information for the purpose of my care and well-being (including by encrypted email). By doing so, I understand that certain information eg. investigation results, may be released to other health professionals and / or hospitals who currently, or in the future, have a bone fide interest in my treatment and care.

Print Name:

Signature: Date:

Part B - Collection
At times it will be necessary to obtain information about you from a third party, eg medical facilities such as hospitals or other health professionals.

GENERAL CONSENT
FOR THE COLLECTION OF
PERSONAL / MEDICAL INFORMATION

Provided that Peninsula Respiratory Group and staff do their best to maintain the confidentiality of my medical record, I hereby consent to the collection of personal / medical information from a third party for the purpose of my care and well-being.

Print Name:

Signature: Date: