SYDNEY ENDOCRINOLOGY

Patient Registration Form

Title: Mr Mrs Miss Ms Dr Master Other: _____

Given Names: _____ **Surname:** _____

Date of Birth: _____ **Email:**_____

Phone: (H) _____ **(W)** _____**(M)** _____

Street Address: _____

Suburb:_____ **Post Code:** _____

Postal/Billing Address (If Different): _____

Parents Name (if child) _____

Emergency contact: _____ **Phone:** _____ **Relationship**: _____

Medicare No: _ _ _ _ _ _ _ _ _ _ _ **Ref Number:**_____**Exp:** _____

Health Fund: _____**Membership Number:**_____

Veteran Affairs No: _____**Exp:** _____

Pensioner No:_____**Exp:**_____

Referring Doctor: _____ **Practice Name**:_____

Practice Suburb: _____ **Phone number**:_____

GP: _____ **Practice Name**: _____

Practice Suburb: _____ **Phone number**:_____

How did you hear about us?	**GP** ☐	**Google** ☐	**Social Media** ☐	**Friends/ Family** ☐	**Other (Pls state)** _____

Permission to Collect and Store Information:

I have read the above and agree to the collection and storage of information. I authorize Dr K.Tonks/ Dr M.Fazekas-Lavu/Dr J.Shrosbree/Dr J.Lasschuit/Dr N. Lenders/Dr L Lamb/Dr J Snaith to release medical information to the Referring Doctor/ Insurance Company/ Solicitor or the other persons nominated by me. I understand my information may be audited to improve practice in such a way that can't be identified. I am aware that as a private patient payment is expected at the time of consultation and that a $100 re-booking fee applies for all cancellations made with less than 24 hours' notice before your scheduled appointment. I undertake to pay any additional fees incurred in recovering overdue and non-attendance fees (including cancellation at short notice).

SIGNED: _____ DATE: _____