Dr Arunaz Kumar

Patient Registration

Full Name (Mrs, Miss, Ms):_____

Address:_____

_____

_____

Postal Address: (If different from above)

_____

_____Post Code:_____

Date of Birth:____/____/_____ Age:_____

Telephone: (H)_____ (W)_____(M)_____

Occupation:_____

Do you have Private Health Insurance: Y_____ N_____
Health Fund_____ Membership Number_____
Have you had Health Insurance for more than 12 months? _____

Medicare Number:_____Reference: _____Expiry:_____

EMAIL ADDRESS : _____

Husband / Partner / Next of Kin:_____Contact No:_____

Referring Dr: _____
Address:_____

_____

Please note: This practice does automatic SMS reminders.

Payment of Account:
Practice policy is for full payment of your account on the day of consultation.
Please discuss any financial difficulties that your account may present to you with the doctor or the practice manager.
Accounts outstanding for more than 60 days will be placed in the hands of a debt collector without further notice to yourself and associated costs incurred will be payable by the patient.

I have read and understood the above

Patients Signature :_____ Date: _____

Please turn over to complete privacy consent.

PRIVACY LEGISLATION CONSENT

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 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 your provide in the following ways:

- Administrative purposes in running our medical practice including our insurer or Medical Indemnity Provider.
- Billing purposes, including providing information to Medicare and your Health Insurer and any organisation responsible for the financial aspects of your care.
- Disclosure to other involved in your health care, including treating doctors and specialists outside this medical practice.
- Disclosure to enable recording on medical registers.
- Disclosure to other doctors in the practice, locum and students attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes and your record will be noted accordingly.

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 health care 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.

Patient Signature: _____ **Date:**_____

Name (Printed):_____