

# Patient Registration Form - Dr. D'Arcy-Evans

Miss/Ms/Mrs	Surname	First name	Date of birth
Home Address:			
Home phone		Work phone	
Mobile phone			
Email contact			
Occupation			
Medicare number	Reference number (left of name)	Expiry date	
Private health fund	Membership number	Type of cover HOSPITAL/EXTRAS/BOTH	
DVA file number		Gold card/White card/Other (please specify)	
Workcover reference number (if applicable)			
GP name		GP suburb	
Emergency contact (Next of Kin) Name Relationship		Telephone number	
<p>Due to Privacy Legislation, we require your consent to collect personal information. This practice collects your information in order to identify your medical record and to provide an accurate, quality health service. This means we will use the information that you provide in the following ways:</p> <ul style="list-style-type: none"> <li>★ Administrative purposes in running a specialist medical practice; including preoperative and postoperative calls using phone numbers and names that you have provided to us, as well as hospital interaction for booking surgical or delivery services.</li> <li>★ Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.</li> <li>★ Disclosure to others involved in your medical care, including treating doctors, specialists and hospital booking staff outside this practice. This may occur through referral to other doctors, surgery at hospitals, for medical tests and in the reports or results returned to us following referral.</li> </ul> <p>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 and treatment provided to me. I am aware of my right to access the information collected about me, except in circumstances where access might be 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.</p> <p>I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.</p>			
_____		_____	
Patient signature		Date	
Privacy brochure taken      YES    NO			

**Would you like SMS appointment reminders? YES NO**

**How did you hear about us?.....**

**EMAIL THE COMPLETED FORM TO: [reception@darcyevans.com.au](mailto:reception@darcyevans.com.au)**