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# PATIENT REGISTRATION FORM – DR MICHAEL WINES

Information supplied by you is kept strictly private and confidential and will assist in providing the best possible care for you.

## PATIENT DETAILS

*Please complete **ALL** sections below*

*Title*: ..... *Date of birth*: ...../...../.....

*First Name*: ..... *Surname*: .....

*Language spoken at home:* .....

*Address*: *Street*:.....

*Suburb*: ..... *Postcode*: .....

*Telephone*: *Home* ..... *Mobile* .....

*Private Email*: .....*Occupation*: .....

❑ I consent to receiving medical information such as test results/request forms via the email I have provided

*Next of kin details: Name*: ..... *Relationship:* .....

*Primary telephone number:* ..... *Secondary telephone number:* ……..……..…..

## MEDICARE AND HEALTH INSURANCE DETAILS

*Medicare number*: ..... *Ref*: ..... *Expiry date*: .....

*Private health fund*: ..... *Membership number*: .....

*DVA card number:* ..... *Card type:* Gold / White

*Is this an iCare or Workers Compensation claim? If yes please provide the following:*

*Case Manager:* ……..…… *Claim Number:* …….……..... *Mobile:/Email* ..……...

## YOUR LOCAL DOCTOR'S DETAILS

*GP's Name*: ..... *Suburb*: …….....

*Were you referred by your GP?* Yes / No

*Name of referring doctor if different to your GP*..... ***(continued over)***

## MEDICAL HISTORY

Patient name:.....

*Do you have any allergies: eg medications, latex* Yes / No *If yes, please list them*:

.....

*Do you currently smoke?* Yes / No *Have you ever smoked?* Yes / No *For how many years?* ……..

*Do you drink alcohol regularly?* Yes / No

*Do you take any blood thinning medications?* Yes / No (e.g. Aspirin, Warfarin, Clopidogrel, Rivaroxaban, etc.)

*Please list any medical problems and conditions:* *Please list all past surgeries:*

..... .....

..... .....

..... .....

*Please list all your current medication including herbal preparations:*

..... .....

..... .....

..... .....

## PRIVACY

From December 21, 2001, the Federal Privacy Act of 1988 was amended to apply to all doctors in private practice. It is required that a fully informed voluntary consent is obtained before or as soon as practical after the collection of health information.

Providing you with the best care requires a full knowledge of your health information by all members of a medical team, which may be shared from time to time, including by electronic means. This may include referring and consulting doctors, allied health staff, pathology, radiology, anaesthetists, Medicare, private health funds and debt collections agencies.

Consultation fees are expected to be paid in full at the time of your appointment. These fees are above the Medicare Benefits Schedule (MBS) fee. You will be able to claim the MBS benefit from Medicare with the receipt issued if you have a valid GP/Specialist referral. I agree to take responsibility for the complete and timely payment of all my accounts.

Your health information may be used in a de-identified manner for surgical audits, clinical research, etc. Record keeping may also include medical imaging and photographs. *The privacy of individuals is strictly maintained when reporting results of audits or research to the profession.*

❑ I have read and understood the above and consent to information, medical imaging and photographs being used for the secondary purpose of audit and research by Dr Michael Wines and associates. I also consent to medical records and medical imaging being destroyed after seven years if I am no longer being treated by Dr Michael Wines

❑ I consent to information being uploaded to MyHealth Record

If you have any questions in relation to this consent form or our Privacy Policy, please ask our staff for more details.

*Full name:* ..... *If guardian, relationship to patient* ……..

*Signed:* ..... *Date:* .....