

Dr Kevin Lowe - Patient Registration Form

Ms/Miss/Mrs/Mr	Surname	First Name	Date of Birth
Home address		Postal address (if applicable)	
Street		PO	
Suburb		Suburb	
Postcode		Postcode	
<input type="checkbox"/> Home phone:		<input type="checkbox"/> Mobile	
<input type="checkbox"/> Email:			
Occupation:		<input type="checkbox"/> Work phone:	
<i>Please indicate above with a <input checked="" type="checkbox"/> your preferred method of contact</i>			
Private Health Fund:		Fund Number:	
Medicare Number: _____		Expiry Date: / /	
Patient Reference Number on Card ____ <i>(this is the number to the left of your name)</i>			
Pension/Health Care Card Number:		Expiry Date: / /	
Person/Entity responsible for account:		<input type="checkbox"/> Self	
<input type="checkbox"/> Veterans' Affairs <input type="checkbox"/> Department of Defence <input type="checkbox"/> Other _____			
Veterans Affairs Number:		Expiry: / /	
Contact in case of an Emergency:		Telephone:	
Name:			
Allergies		Pregnant: Yes / No	

Past Significant Medical History (if applicable):

Important:

Is your current medical condition the subject of any WorkCover or Workers Compensation Claim? Please circle Yes or No.

Are you making, or have you ever made, or intend to make an insurance or liability claim in regard to this medical condition? Please circle Yes or No.

Please note: any correspondence arising from your consultations with Dr Kevin Lowe is not to be used for Medico-legal purposes, nor given to a third party *without his explicit written permission.*

Patient Privacy:

This Practice has a commitment to providing a quality health service that complies with all the Australian Privacy Principles as stated in The Privacy Amendment (Practice Sector) Act 2000. Information about you, which is collected by our professional staff, helps them give you the best possible care in all stages of your assessment, diagnosis, treatment and referral. As a result, we require you consent to do so. This means we will use the information you provide in the following ways:

- Administrative purposes in running a specialist medical practice; including pre-operative and post-operative calls using phone numbers and names you have provided to us, as well as hospital interaction for booking surgical or delivery services
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements and third party providers in the event of non payment
- Disclosure to others involved in your medical care, including treating doctors, specialists, 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 the referrals.

I have read the information above and understand the reasons why my information must be collected. 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 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 purpose set out above, subject to any limitations on access or disclosure I notify this practice of.

Patient Signature

Date

Ultrasound Consent:

This Practice adopts Best Practice standards and has a commitment to providing a quality health service that complies with all legislative instruments. Although consent is not a requirement within the public health system for an ultrasound service, privately we require consent to facilitate this and comply with Accreditation systems.

Ultrasound:

- An ultrasound is a procedure that uses soundwaves to take pictures. Ultrasound DOES NOT use radiation.
- An ultrasound is a painless procedure, no anaesthetic is required
- Lights in the room may be dimmed so that the pictures can be viewed more clearly
- Ultrasound gel will be put on the examination area which allows the probe to slide easily over the skin. This will be wiped off once the scan is complete.
- Should I consent to treatment, I may or may not require a local anaesthetic and relevant information regarding this procedure will be discussed directly with me and verbal consent obtained prior to performing.
- Ultrasound pictures may be taken

I have read the information above and understand the reasons why my consent is required. I understand that I am not obliged to provide consent to an ultrasound, but that my failure to do so might compromise the quality of health care and treatment provided to me

I consent to an ultrasound scan by this practice for the purpose set out above.

Patient Signature

Date