

MR SIMON E SMITH

Patient Registration Form

Podiatric Surgeon – Reconstructive Foot Surgery

ESSENDON 961 Mt. Alexander Road, Essendon VIC 3040

GEELONG 200 Malop Street, Geelong VIC 3220

RINGWOOD 36 Wantirna Road, Ringwood VIC 3134

Phone (03) 9379 8816 Fax (03) 8678 3938

Name: _____

Address: _____

Suburb: _____ Postcode: _____

Contact No: Home: _____ Work: _____

Mobile: _____ Email: _____

Date of Birth: _____ Age: _____

Occupation: _____

Next of Kin: _____ Relationship to patient: _____

Phone: _____ Mobile: _____

Name of Referring Practitioner: _____

Contact Details: _____

Name of GP: _____

Contact Details: _____

Name of Podiatrist: _____

Contact Details: _____

Private Health Insurance Fund: _____ Member Number: _____

Medicare Number: _____ Expiry: _____

Privacy Statement:

Recent requirements under the Health Privacy Act state that we now require your consent to collect information about you. We require you to provide us with your personal details and a 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 you provide in the following ways:

- Administration purposes in running our practice
- Billing purposes, including compliance with Health Insurance Commission requirements
- Relating your information to others involved in your care, including your general practitioner and specialists outside this practice. This may occur through referral to other doctors or for medical tests.

Please let us know if you do not want your records accessed for these purposes and we will note this in your record accordingly. If you consent to the handling of your information for the purposes set out above, please sign and date below.

Name: _____ Signature: _____ Date: / /