

DR MARK JALLAND

REGISTRATION FORM

(Please Print)

| | | | | | | | |
|--|--|----------------------------------|-------------|---|---|---|---|
| Today's date: | | | | | | | |
| PATIENT INFORMATION | | | | | | | |
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If not, what is your legal name? | | (Former name): | | Birth date: / / | Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | | Home phone: | | Mobile phone no.: | | |
| P.O. box: | | City: | | State: | | Area Code: | |
| Email: | | | | | | | |
| Medicare No | | | | | | Ref: Exp: | |
| Pension/Healthcare card No: | | | | | | | |
| Veteran Affairs No | | | | | | Color: | |
| | | | | | | | |
| Referring Doctor: _____ | | | | | | | |
| Regular GP: | | | | | | | |

| | | | |
|---|------------|---|-------------------------------------|
| INSURANCE INFORMATION | | | |
| | | | |
| Person responsible for bill: Only complete if different from patient. | | Birth date: / / | Address (if different): () |
| Your relationship to patient: Please circle: Self Spouse Child Other | | | |
| Insurers Name: | Member No: | Please circle level of cover: Hospital: Basic Intermediate Top (Gap cover) Extras only. | Medicare No: Ref No: Expiry: |

| | | | | |
|--|--|--------------------------|------------------------|------------------------|
| IN CASE OF EMERGENCY | | | | |
| Name of next of kin: | | Relationship to patient: | Home phone no.: () | Work phone no.: () |
| It is the policy of this practice to have payment on the day of consultation. In the case of an operation payment is due within 30 days. In the event of late payment, the practice reserves the right to charge interest (CBA bank card interest) and should it be necessary to forward to your account to a Debt Collection Agency, the patient is liable for payment of commission charged by the agency and will be liable for any legal costs incurred in process of the recovery of debts owed by the patient. | | | | |
| Patient/Guardian signature | | | Date | |

MEDICAL HISTORY

| | | |
|------------------|-------------------------------|-------------|
| Allergies | | |
| Past history of: | Asthma | Yes No |
| | Heart Disease | Yes No |
| | Epilepsy | Yes No |
| | Thyroid Disease | Yes No |
| | High Blood Pressure | Yes No |
| | UTI (urinary tract infection) | Yes No |
| Other: | | |
| Other: | | |
| Other: | | |

CURRENT MEDICATION

PREVIOUS OPERATIONS

CURRENT INVESTIGATIONS

Privacy Information and Consent Form

The information collected will be used for the following:

- Administration purposes.
- Billing purposes – including Medicare and private health billings.
- To disclose information to the required specialists or treating doctors outside of this practice. This may be done in the form of referrals or medical investigations.
- We also send correspondence to your referring doctor, which will have results or relevant information released.
- Any relevant information that is required to go on the theatre consent forms will also be released to the participating hospital.

By signing this form:

I understand that I am obliged to give all the requested information in relation to me. I also understand that if I do not give all my information correctly it restricts Dr Jalland in his ability to provide the treatment that is required.

I have read the above information and am fully aware of the reasoning behind asking all the required information.

I am aware that this practice will handle my information accordingly to the privacy act.

I acknowledge that I have stated all answers are honest and truthful.

I acknowledge that I have read the above statements and have clarified with staff members any confusion that may arise.

Patient name: _____

Patient Signature: _____

Date: _____

Parent/Guardian Signature:

If under the age of 18.

| Have you had any of the following | Where was this completed | When |
|-----------------------------------|--------------------------|------|
| Blood Tests: | | |
| Ultrasound: | | |
| Smear Test: | | |
| | | |
| Other: | | |
| | | |
| | | |
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