



# Ear, Nose and Throat Victoria

Mr Patrick Guiney, Mr Bernard Lyons,  
Mr Timothy Baker, Mr Halil Ozdemir

Ear, Nose & Throat/Head & Neck Surgeons

Suite 1, 28-32 Arnold Street  
Box Hill, Vic 3128

Ph: (03) 9895 0400  
Fax: (03) 9895 0444

## PATIENT REGISTRATION FORM

SURNAME:.....Mr/Mrs/Ms/Master/Miss.....

GIVEN NAMES:.....Date of Birth:...../...../.....

ADDRESS.....P/C:.....

POSTAL ADDRESS:.....P/C:.....

TELEPHONE:(HOME).....(WORK).....

(MOBILE).....OCCUPATION:.....

NAME & ADDRESS OF PERSON RESPONSIBLE FOR ACCOUNT/PARENTS NAMES:

.....  
.....

PRIVATE HEALTH FUND.....M/SHIP NO:.....

MEDICARE NO: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ EXPIRY DATE: ...../.....

REFERENCE NO. (to the left of name):      1      2      3      4      5      6      7

PENSION NO..... (does not include Healthcare Card)

VETERANS AFFAIRS NO.....

TAC/WORKCOVER NO:.....

In accordance with standard business practice, payment is requested at the time of consultation. Cash, personal cheques and credit cards are accepted. We also offer EFTPOS facilities. There may be additional charges associated with your consultation for various tests required to assess the condition. Your account is claimable from Medicare for the consultation and any additional tests. All account and payment queries should be directed to the reception team on 9895 0400.

I acknowledge that I am personally liable for fees resulting from consultations, hearing tests and diagnostic or therapeutic procedures for the above patient.

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

### PLEASE READ AND SIGN BACK OF THIS FORM



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**We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.**

This medical practice collects information from you for the primary purpose of providing quality health care. 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:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or 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 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 the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some 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 purposes set out above, subject to any limitation on access or disclosure that I notify this practice of.**

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

Full Patient Name:..... DOB:.....