REGISTRATION FORM

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION		
Date: _____/_____/_____	Title: Mr / Mast / Mrs / Ms / Miss	Marital Status:
Patient's surname:	First Names:	Date of Birth: ____/____/_____
Residential Address:	Postal Address:	
Home phone no:	Mobile:	Email address:
Occupation:	Do you consent to receiving correspondence via email? YES/NO	

Is this patient currently under the care of DHHS or Child protection? YES / NO

Case Manager: _____ Contact number:_____Carer:_____

INSURANCE INFORMATION		
(Please present your insurance & Medicare card to the receptionist)		
Medicare Card #: _____	Reference #: ___	Expiry Date: ___/____
Private Health Insurance Fund:	Membership #	Level of cover:
Pension Card #	HC Card #	DVA # WHITE/GOLD
Is this related to a work cover claim?	Claim #	Date of Accident:
Person Responsible for account:	Contact Number:	Address (If different to above):
Referring Doctor:	Medical Clinic:	Usual GP:
IN CASE OF EMERGENCY		
Next of Kin / Emergency Contact:	Relationship to patient:	Contact Number:

DECLARATION:

I _____ declare the above information is true to the best of my knowledge.

I understand that I am financially responsible for all out of pocket expenses not covered by Medicare or relevant private health insurance. I also authorize Essential ENT Victoria to obtain any relevant and necessary results and / or reports from 3rd parties as required for my treatment and care.

Patient/Guardian Name Signature Date

EssentialENT VICTORIA

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MEDICAL HISTORY

Do you have any of the following medical conditions? (Please circle)

- High Blood Pressure YES / NO
- Diabetes YES / NO
- Arthritis YES / NO
- Do you drink alcohol? If yes how often? YES / NO
- Do you / have you ever smoked cigarettes? YES / NO

MEDICAL CONDITIONS:	
MEDICATION:	**DOSAGE:**
ALLERGIES:	**REACTION:**
PREVIOUS OPERATIONS:	**LOCATION:** **YEAR:**