Westside ENT

New Patient Registration Form

Please complete and submit this Registration Form online prior to your visit. Alternatively, download, complete and return the Registration Form via fax, email or post or just bring it with you on the day.

Phone: 07 3202 4636 **Fax:** 07 3202 4475
Email: info@westsideent.com.au
Post: WestsideENT 16 Pring St Ipswich Qld 4305
Website: westsideent.com.au

Patient Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

Full Name: DOB:

Address:

Suburb: State: Postcode:

Email: Mobile:

Home Phone: Work Phone:

Medicare Details

Medicare No: Ref No: Expiry Date:

Parent/Carer Details If Patient is a Minor

Full Name: DOB:

Medicare Ref Number:

Next of Kin/Emergency Contact

Name: Relationship: Contact Number:

Private Health Fund Details

Level of Cover: ☐ Uninsured ☐ Hospital Cover ☐ Extras Cover Only

PHF Name: PHF Membership No:

Dept of Veterans Affairs Details

DVA Card: ☐ Nil ☐ Gold Card ☐ White Card

DVA Card Number: DVA White Card Approved Condition:

Referring Doctor Details

Referring Doctor's name: Clinic Suburb:

GP Name (if not referrer): Clinic Suburb:

SMS Appointment Reminder

Do you wish to receive appointment reminders via SMS? ☐ Yes ☐ No

Privacy Information

To enable the ongoing provision of care within this practice, and in keeping with the Privacy Act 1988 and Australian Privacy Principles (APPs), we wish to provide you with information on how your personal and health information may be used or disclosed. WestsideENT collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. Your personal and health information will only be used for the purposes for which it is collected, or as otherwise permitted by law.

Consent

I have read the information above and understand the reasons why my information must be collected. I am also aware that WestsideENT has a Privacy Policy on handling patient information which is displayed on its website. I consent to the use of my personal and health information by WestsideENT and other health providers involved in my medical care. I consent to the disclosure of my personal and health information by WestsideENT to other health providers directly or indirectly involved in my personal health care or medical treatment.

I give my consent to WestsideENT to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care. I authorise those medical practitioners or bodies to release such information, which may include sensitive health information, to WestsideENT as may be requested.

☐ **Yes, I give my consent.** Signature _____ Date _____

Medical Information

Medical Conditions (Please tick all that apply)

☐ High blood pressure
☐ Cardiac Bypass Surgery
☐ Blood Clots / Pulmonary Embolism / DVT
☐ Chronic lung disease/COPD
☐ Stroke
☐ Cardiac Stents
☐ Asthma
☐ Atrial Fibrillation
☐ Heart Attack
☐ TIA
☐ Diabetes

Bleeding Disorders

Do you have a history of any bleeding diseases? ☐ Yes ☐ No

Is there a family history of any bleeding diseases? ☐ Yes ☐ No

Do you take any of these medications?

☐ Aspirin
☐ Anti-inflammatory drugs eg neurofen, brufen, celebrex, voltaren
☐ Eliquis (apixaban)
☐ Pradaxa(dabigatran)
☐ Plavix (clopidogrel)
☐ Warfarin
☐ Xarelto (riviroxaban)

Current Medications:

Allergies:

Smoking & Alcohol History

☐ Current smoker ☐ Non Smoker ☐ Former smoker

No of years smoking: ____ No of cigarette per day: ____ Quit Date: ____

Do you drink alcohol? ☐ Yes ☐ No Drinks per week: ____