PATIENT REGISTRATION FORM

PATIENT'S GIVEN NAMES: .....

SURNAME: .....

DATE OF BIRTH: ..... SEX: MALE / FEMALE

NAME OF MOTHER: ..... FATHER: .....

ADDRESS: .....

..... POST CODE: .....

PHONE No: HOME ..... WORK .....

MOBILE ..... EMAIL .....

MEDICARE No: ..... REF No: ..... EXP DATE: ..../.....

IS YOUR CHILD COVERED BY PRIVATE HEALTH INSURANCE with *HOSPITAL* COVER? – YES / NO

IF YES, NAME OF PRIVATE HEALTH FUND: .....

MEMBER NUMBER: .....

HAVE THEY BEEN A MEMBER FOR MORE THAN 12 MONTHS? – YES / NO

NAME OF GENERAL PRACTITIONER: .....

NAME OF REFERRING DOCTOR (If not usual GP): .....

NAME OF ANY OTHER HEALTH PROFESSIONALS INVOLVED IN YOUR CHILD'S CARE

(eg. Paediatrician, Speech Therapist, etc): .....

HAS YOUR CHILD PREVIOUSLY SEEN ANOTHER ENT SURGEON? – YES / NO

IF YES, WHICH ENT SURGEON(S)?: .....

HOW DID YOUR CHILD COME TO BE REFERRED TO DR WABNITZ?

- ☐ GP Recommendation
- ☐ Specialist Recommendation
- ☐ Family Member Treated by Dr Wabnitz
- ☐ Recommendation by Family / Friend
- ☐ White Pages / Yellow Pages Search
- ☐ Internet Search
- ☐ Other – please specify:

I hereby agree to pay for all financial charges arising from the medical consultation and associated services provided by Dr David Wabnitz. I also consent to the handling of information provided to this practice by me in accordance with their Privacy Policy, subject to any limitations of which I may notify Dr Wabnitz's practice.*

SIGNED: ..... DATE: .....

**Copy of Privacy Policy available from Administration Staff and can also be viewed on www.wabnitzent.com.au*