Sydney South East Psychiatry
Shop 4, 155 Avoca Street RANDWICK NSW 2031 Phone: 1800 779 243 Fax: 02 8823 1843

## **NEW PATIENT REGISTRATION FORM**

<b>Date:</b> / /			
□ Mr □ Mrs □ Ms □ Miss □ Dr			
Surname: Given Names:			
Date of Birth: / /			
Postal Address:			
Postcode:			
Phone number Home: Mo	bile:	Work:	
Email address:			
Preferred method of communication: □	Phone   □ Email		
Occupation:			
Emergency Contact Person: Contact number:	Relationship	to you:	
GP Name:	Specialist Name:		
<b>Referred by:</b> □ GP □ Specialist			
What is the name of your referring doctor?			
<b>DVA</b> : Gold Card □ White Card □ DVA Card Number:			
Medicare Number:	Patient ID: Exp Date	/	
Do you have private health cover? ☐ Yes ☐ No			
Health Fund Membership	Number		-
Does your insurance cover you for Priva	te Hospital Admission?	□ Yes	□ No
Will this be an insurance or workers compe	nsation claim?	□ Yes	□ No
PRIVACY STATEMENT			
<ul> <li>To comply with the Privacy Act 2001, all patients need to provide written consent for the following aspects of their medical care:         <ul> <li>I agree that Dr Gordon Hyde takes a full medical history that relates to my medical condition and management</li> <li>I agree that relevant information may be obtained from other medical practitioners, such as GP's and specialists, other health care providers, pathologists and hospitals as necessary.</li> <li>I agree that Dr Gordon Hyde may discuss my medical history, diagnosis and management with my GP and other relevant specialists in relation to my medical management.</li> <li>I understand that I may apply to access my health records.</li> </ul> </li> </ul>			
PATIENT NAME			
PATIENT SIGNATURE	DATE		