Sydney South East Psychiatry

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NEW PATIENT REGISTRATION FORM

Date: / /

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Surname: **Given Names:**

Date of Birth: / /

Postal Address:

Postcode:

Phone number Home: Mobile: Work:

Email address:

Preferred method of communication: ☐ Phone ☐ Email

Occupation:

Emergency Contact Person: Relationship to you:
Contact number:

GP Name: **Specialist Name:**

Referred by: ☐ GP ☐ Specialist

What is the name of your referring doctor?

DVA: 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 Private Hospital Admission? ☐ Yes ☐ No

Will this be an insurance or workers compensation claim? ☐ Yes ☐ No

PRIVACY STATEMENT

To comply with the Privacy Act 2001, all patients need to provide written consent for the following aspects of their medical care:

- **I agree that Dr Gordon Hyde takes a full medical history that relates to my medical condition and management**
- **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.**
- **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.**
- **I understand that I may apply to access my health records.**

PATIENT NAME ……..

PATIENT SIGNATURE……...**DATE**……