

PATIENT REGISTRATION FORM



Sonacare

Women's Health & Ultrasound

TITLE: Choose an item.	<input type="text"/>	<input type="text"/>
	(surname)	(first & middle name)
Date of Birth: ____/____/____ (DD /MM /YYYY)		
Address: <input type="text"/>		Post code: <input type="text"/>
Postal address (if different from above): <input type="text"/>		Post code: <input type="text"/>
Contact Details		
Home: <input type="text"/>	Mobile: <input type="text"/>	
Work: <input type="text"/>	Email: <input type="text"/>	
Appointment reminders will be sent via SMS 2 days before your scheduled appointment. Please tick box if you DO NOT wish to be reminded of your appointment via SMS.		<input type="checkbox"/>
At times, email may be used to communicate with you. Your email address will not be published. Please tick box if you DO NOT wish to have email correspondence from us.		<input type="checkbox"/>

Medicare No: 10 DIGITS <input type="text"/>	Ref No: <input type="text"/> (number next to your name)	Expiry Date: <input type="text"/>
Health Fund Name: <input type="text"/>	Membership No: <input type="text"/>	UPI: (number <input type="text"/> next to your name)
Occupation: <input type="text"/>	Language spoken: <input type="text"/>	

Emergency Contact		
Partner name: <input type="text"/>	Contact number: <input type="text"/>	
Next of kin (if different to above): <input type="text"/>	Relationship to you: <input type="text"/>	
	Contact number: <input type="text"/>	

Your General Practitioner /Local Doctor	
Name: <input type="text"/>	Phone: <input type="text"/>
Address: <input type="text"/>	Fax: <input type="text"/>

Your Referring Doctor (if different from above)	
Name: <input type="text"/>	Phone: <input type="text"/>
Address: <input type="text"/>	Fax: <input type="text"/>

Correspondence will automatically be sent to your referring doctor and copied to your GP/ local doctor. Please inform your specialist if you do not want correspondence sent.

How did you hear about us?	GP/Specialist <input type="checkbox"/> Friend/Family <input type="checkbox"/> Google <input type="checkbox"/> Walked past <input type="checkbox"/> Other <input type="checkbox"/>
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Please turn page over

PRACTICE INFORMATION



This document is to inform you of the various policies and procedures that may affect you as a patient attending our service. We require you to read and acknowledge that you have read this document prior to attending our practice.

PRIVACY NOTICE

The personal and health information that is provided by you and recorded in your Electronic Health Record will be collected for the purpose of providing you with treatment. Your information is collected and held in accordance with NSW privacy legislation under which you have rights of access and correction. More information about your privacy rights is available on the internet at www.privacy.gov.au.

Your medical record is a permanent legal document and we take its security very seriously. We can, on written request, provide you or a person nominated by you with a copy of your Health Record. For legal reasons, your request must be made in writing, and approved by your treating practitioner.

CONSENT TO RELEASE OF MEDICAL INFORMATION

I give my consent to Sonacare Women's Health and Ultrasound, or their agent and advisors, to contact medical practitioners or other bodies who I have consulted, to obtain health and other information that may be pertinent to my care. I authorize those medical practitioners or bodies to release such information, which may include sensitive health information, to Sonacare Women's Health, or their agent and advisors, as may be requested. I understand that unless I advise otherwise, Sonacare Women's Health will continue to liaise with the doctors nominated by me on matters related to my ongoing care.

I have read and understood the above Privacy Policy and release of medical information
Initials_____

CANCELLATION POLICY

Sonacare is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call reception on (02) 4623 8633 by 4p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 4p.m. on Friday. If prior notification is not given, you will be charged for the missed appointment.

Cancellation fees Late cancellation (after 4 pm the day before) 50% of normal consultation fee will be charged
Missing a scheduled appointment 100% of normal consultation fee will be charged

I have read and understood the above Cancellation Policy.

Initials _____

RESEARCH CONSENT

Your information may be used by Sonacare Women's Health, to evaluate by the way of research or audit, the service and/or medical treatment that you have received. Any information that you provide for the audit or research purposes will not identify you in any way.

I DO CONSENT to my information being used for research/audit purpose.

I DO NOT CONSENT to my information being used for research/ audit purpose.

Initials _____

YOUR ACKNOWLEDGEMENT

I have read and understood the above information and policies regarding Sonacare Women's Health and Ultrasound. I reserve the right to change my consent at any point on written request. I understand that my acknowledgement of above will be recorded in my Electronic Health Record.

_____/_____/_____
Print First Name *Print Last Name* *DOB*

_____/_____/_____
Signature *Today's Date*

Thank you for taking the time to read this information.