EASTERN NEPHROLOGY

Renal Medicine and Hypertension Physicians

Dr. Vatsa Dave BHB, MBChB, FRACP. 4160836A
A/Prof Darren Lee MBBS(Hons), PhD, FRACP. 2418859B
Dr. Sid Rajakumar MBBS (Hons), FRACP. 241860FT
A/Prof Louis Huang MBBS, PhD, FRACP. 252597EY
Dr. Michael Hsieh MBBS, FRACP. 242020MH
Dr. David Lau MBBS, FRACP, M.med. 242009ET
Dr. Jane Love MBBS, FRACP 4914445W
Dr. Parul Bali MBBS, MPH, FRACP. 468504PL
Dr. Fei Fei Mary Pan MBBS/BA, FRACP. 272949BY

Epworth Eastern - East Wing Tower
Suite 13.7, 1 Arnold St,
Box Hill VIC 3128

P: 9895 7642
F: 9895 7612
Healthlink EDI: buckleyw
W: www.easternnephrology.com.au
E: info@easternnephrology.com.au

NEW PATIENT REGISTRATION

MR / MRS / MISS / MS (please circle one)

SURNAME …….. **Given name**……..

ADDRESS ……

POSTCODE ……..……..……..**EMAIL**……..……..

TEL: HOME……..……... **WORK** ….……..…. **MOBILE**……..

DATE OF BIRTH…… **OCCUPATION** ……

Referring Doctor and address ……..……

……..……

GP name and address (if different to the referring doctor)……..…..

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……..……

OTHER MEDICAL SPECIALISTS……..……

……..……

PRIVATE HLTH INSURANCE ……**MEMBERSHIP NO**……..……

MEDICARE NO……..……*patient no*……..…… **Expiry date**……..……
(The patient number is to the left of your name on the card (usually 1,2,3,or 4)

Pensioner or Health Card details …… **Expiry date**……..……

Veterans' Affairs no (if applicable) ……..……

PREVIOUS PATHOLOGY COMPANY ……..……..

Due to current privacy laws, all patient information is confidential. If you wish any information to be shared with a relative or other person, please record name and relationship. By nominating a person, it advises us that you consent to confidential information being released to the person's named below

NAME……..……..……RELATIONSHIP……...……MOBILE .....……..……..

We may need to obtain old results and reports from your treating doctors and hospitals - if you are happy for us to do so, please sign below.

I authorise Eastern Nephrology to obtain results from my treating doctors/hospital records and have no objection to my letters/results being transmitted via email for expediency

Signature……..…… Name ……..……Date……..……

PRIVACY POLICY

This clinic collects information from you for the primary purpose of providing quality health care. Federal Privacy Law requires your consent to this. We need your personal details and full medical history (which may include photographic records) so that we may properly assess, diagnose, treat and manage your health care needs. This means we will use the information you provide in the following ways:

- Adminstrative purposes in running our medical practice, which may include confirmation of your appointment via SMS or email
- Billing purposes - including, but not limited to, compliance with Medicare and the Health Insurance Commission requirements .
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports of results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums and trainees attached to the practice for the purpose of patient care and teaching.
- Emergency situations whereby medical officers/hospitals may require access to patient notes for treatment purposes.

CONSENT

- I have read the above information and understand the reasons why my information must be collected
- I understand that I am not obliged to provide any information requested, but that failure to do so might compromise the quality of the health care and treatment given to me
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld and that an explanation will be given to me in this circumstance
- I understand that if my information is to be used for any purpose other than the above, this clinic will seek my consent prior
- I consent to this clinic using my personal information in the ways outlined above.
- I understand that consultations are not bulk billed &/or not payable by private health insurance, and fees are payable on the day of consultation.
- I also understand that if there is a need for a procedure or treatment, there will be additional fee for these.
- I understand for security purposes the common area at this clinic is under video surveillance.
- I understand that my results will be communicated from the treating Doctor via primary sms/ email contact provided and that a phone call from clinic staff will follow to plan any associated treatment.
- I understand I am responsible to call for my results if I have not had my results confirmed a week after my appointment.

Name: _____

Signature: _____ Date: _____