Specialist Centre
BALLARAT

108 Drummond Street North, Ballarat VIC 3350
Phone: (03) 5331 8289 Fax: (03) 5331 2545
appointments@scballarat.com.au
www.scballarat.com.au

Patient Registration Form

Please complete all fields.

Date of appointment

Your consulting Doctor/Allied Healthcare Practitioner at Specialist Centre Ballarat (please tick below):

Mr Bruce Stewart ☐	Mr Andrew Lowe ☐	Dr James Ross ☐	Dr Emma Gannan ☐	Dr Maree Pekin ☐	Ms Helen Campbell ☐
Dr Carolyn Vasey ☐	Dr Michael Ng ☐	Mr Daniel Wong ☐	Dr Tim Elliott ☐	Dr Dileep Mangira ☐	Dr Jong Khen Chin ☐

Title Mr / Mrs / Miss / Ms / Dr Surname

Given Names

Date of Birth

Residential Address

City State Postcode

Postal Address

City State Postcode

Phone (Home) Phone (Business) Mobile

Email

Medicare no. Ref no. *(number in front of your name)* Expiry

Private Health Insurance Y / N

Name of Health Fund Member no.

Have you served your waiting period on your Health Fund? Y / N *Do you have an excess to pay on your Health Fund?* Y / N

Pension no. Expiry

(Blue pension card only - NOT healthcare card)

Dept Veteran's Affairs Gold / White Card no.

Workcare or TAC no. *Please bring relevant paper work.*

Referring Doctor

Name of Usual Doctor

Emergency Contact: Name

Relationship Phone

Consent to Privacy Policy (please tick below):

☐ I have read and **I agree** with the Privacy Policy of the Specialist Centre Ballarat (see Page 3).

☐ I have read and **I do not agree** with the Privacy Policy of the Specialist Centre Ballarat (see Page 3).

Please return this form with your referral to our office no later than a week prior to your appointment. Thank you.

Patient Medical History

Please complete all fields.

Date of appointment

Patient Name

Height (cm or feet & inches) | Weight (kg/stones) | Date of birth

Do you take blood thinning medication? Y / N

Please TICK if you are taking any of the following ASPIRIN BASED BLOOD THINNING MEDICATIONS:

Aspirin	Asasantin	Aspirin & Dipyridamole	Aspro	Astrix	Cardiprin
Cartia	Dipyridamole	Disprin	Persantin	Princard	Solprin
Spren	Cardasa	Aspro Clear	Diasp SR		

Please TICK if you are taking any of the following OTHER BLOOD THINNING MEDICATIONS:

Apixaban	Brilinta	Clopidogrel	Clopidogrel & Aspirin	Co-Plavix	Clovix
Coumadin	Dabigatran	Duocover	Duopidogrel	Effient	Eliquis
Iscover	Marevan	Persantin	Piax	Piax Plus Aspirin	Plavix
Pidogrel	Pradax	Prasugrel	Rivaroxaban	Ticagrelor	Warfarin
Xarelto	Plavicor				

OTHER BLOOD THINNING AGENT if not listed above. Please name:

Are you a diabetic? Y / N

If yes, is this controlled by medication/insulin? Y / N

Please TICK if you are taking any of the following DIABETIC MEDICATIONS:

Dapagliflozin (Forxiga)	Empagliflozin (Jardiance)	Ertugliflozin (Steglatro)	Xigduo	Jardiamet	Segluromet
Glyxambi	Qtern	Steglujan			

OTHER DIABETIC MEDICATIONS if not listed above. Please name:

Please list any other regular medication you take below:

Medication	*Reason for taking*

Are you allergic to latex or rubber? Y / N

Are you allergic to anything else? Y / N

Allergy	*Type of reaction*

Specialist Centre
BALLARAT

108 Drummond Street North, Ballarat VIC 3350
Phone: (03) 5331 8289 Fax: (03) 5331 2545
appointments@scballarat.com.au
www.scballarat.com.au

Privacy Policy

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following way:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and 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 or results returned to us following the referrals.
- Details of your name, address and phone number may be passed onto debt collection agencies if necessary to recover outstanding dues.

On occasions the practice undertakes training of students, or research activities. In these instances:

Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.

As part of this practice's commitment to improve the quality of care the practice audits the treatment and outcomes of the care delivered to its patients. This usually involves all components of care for a particular disease, including that by other practitioners and institutions. When required, care plans are discussed with other doctors and health care professionals in a multidisciplinary meeting to ensure a coordinated approach. If you do not wish your care to be audited or discussed at multidisciplinary meetings please advise your doctor.

Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my 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. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

I consent to the collection of my information from x-ray, pathology, MRI, medical records from the hospitals, and other people who have been involved in my medical care.

Please acknowledge that you have read this Privacy Policy by marking your consent in the tick box at the bottom of Page 1 of the Patient Registration Form.