CANBERRA HEAD & NECK SURGERY

A/PROF ARDALAN EBRAHIMI

MBBS (Hons), MPH, FRACS. Provider No: 248300KH

Thyroid, Parathyroid, Head & Neck Surgeon

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Garran ACT 2605
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Healthlink EDI: canbrhns

Patient Registration Form

Mr/Mrs/Ms/Miss/Master/Other _____
Title (circle one) **First name** **Surname**

Address _____

Suburb _____ **State** _____ **Postcode** _____

Home Phone _____ **Mobile** _____

Email _____ **Preferred Contact Method** _____

Date of birth _____

Medicare No. _____ **Ref No.** _____ **Expiry** _____

Private Health Fund _____ **Membership No.** _____

Heath Care/Pension Card _____ **Type(circle)** Health Care/Aged Pension/Other

Department of Veterans Affairs Number _____

Card Colour (including conditions covered if White Card) _____

Referring Doctor _____ **Specialist or GP** (circle one)

Usual GP (including practice location) _____

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP? If so, please list them including name, practice, address and phone:

_____

_____

_____

THE PRACTICE MAY CONTACT YOU VIA EMAIL OR SMS. DO WE HAVE YOUR CONSENT? YES NO

NEXT OF KIN/EMERGENCY CONTACT

Name _____ **Phone** _____ **Relationship** _____

PLEASE TURN OVER

PLEASE NOTE: WE ASK THAT YOUR ACCOUNT FOR CONSULTATION BE PAID ON THE DAY OF SERVICE.
WE ENDEAVOUR TO KEEP TO APPOINTMENT TIMES BUT UNFORTUNATELY AT TIMES THIS IS DIFFICULT DUE TO THE COMPLEX NATURE OF A PATIENT'S PROBLEMS. _____

CONSENT TO COLLECT PATIENT INFORMATION

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 medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice, as advised by you.

Signed _____ **Date** _____

Patient Name (Please Print) _____