

Patient Registration Details



Title Given name(s) Preferred name

Surname Address

Suburb Postcode Mobile number

Home phone Tick here to opt out of SMS appointment notifications

Email Date of birth

Medicare number Ref no Expiry date

Private health insurer Member number Extras coverage

Next of Kin - name Next of Kin - contact number

General practitioner name (if different to referring doctor):

General practitioner address

Workcover or TAC - please provide the following details

Claim number Accident or injury date

Employer Contact number

Employer's address

Please indicate if you currently have any of the following conditions:

Diabetes mellitus Asthma or COPD Heart disease Pregnancy

Current medications

Allergies

Please note: you will be asked to pay for your consultation on the day of service. EFT, EFTPOS, Visa and Mastercard credit facilities are available. Accounts that are not paid on the day of service will incur a 10% administrative surcharge. Workcover and TAC patients are responsible for paying the full cost of consultations and may seek reimbursement from Workcover or TAC.

Check this box to acknowledge payment terms

Privacy Consent

We require your consent to collect personal information about you. Please read this form carefully and check the box at the bottom of this page.

Our 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. We will use your medical records:

1. In your medical treatment. This may include disclosure to individuals who are directly involved in your health care (and in any WorkCover or TAC claim) such as your General Practitioner, your other treating doctors and any third party that is appropriately involved with your case. If we refer you to another healthcare professional, such as an anaesthetist, hand therapist or radiology service we will disclose relevant information to them about your personal details and health.

2. To conduct practice audit and medical research. In this case all data is analysed without including your identifying personal details. Audit and research are important in maintaining high standards of medical practice. Audit of surgical practice is a requirement of the Royal Australasian College of Surgeons.

3. To meet a legal requirement – for instance, if we are issued with a subpoena or summons.

Our practice fully complies with the Privacy Act 1988 (Cth), the Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth), the Health Records Act 2001 (Vic) and the My Health Records Act (2012).

Patient declaration

As a patient of Dr Jill Tomlinson or Mr Sina Babazadeh, I acknowledge that:

- I have read the information above and understand 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 may compromise the quality of the health care and treatment provided 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 such circumstances;
- If I have a My Health Record, it may be accessed during my treatment and information may be uploaded to My Health Record by registered healthcare practitioners at the practice;
- 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 the access or disclosure that I notify this practice of;
- I may request access to my personal information, which may be granted in accordance with the practice's Access to Personal Information Policy. I will be provided with a written reason if access is denied;
- I may request an amendment to my personal information if it is incorrect. I will be provided with a written reason if a request for amendment is denied;
- My personal information will not be used for direct marketing or disclosed to overseas recipients;
- I have the right to lodge a complaint about the handling of my personal information if I am dissatisfied, which will be dealt with in accordance with the practice's complaint handling procedure.

Check this box to provide acknowledgement

Photography consent

Photographs can be valuable in assessment, tracking progress and recovery, evaluating the effects of treatment and the passage of time, communicating with other health care professionals who are involved in your treatment, and in education and research. Our practice fully complies with the Privacy Act 1988 (Cth) and the Health Records Act 2001 (Vic) and we offer all our patients the opportunity to place restrictions on the use of these images.

If you wish to advise us of restrictions on the use of your photographs please select as many of the options below as apply to you (or, if you are completing this form on behalf of a child, your child).

I acknowledge that I can place restrictions on the use of my photographs

Patient (or parent/guardian) declaration

I wish to place restrictions on the following potential uses of my clinical photographs (check all that apply):

- do not place images in my medical record as part of my treatment
- do not send to another health practitioner who is treating me for this condition
- do not use my images in de-identified form by health professionals for education and training
- do not use my images in de-identified form in research publications, including but not limited to journal articles and book chapters
- do not use my images in de-identified form on the <http://melbournehandsurgery.com> website for the purpose of patient education
- do not use my images in de-identified form on the practice Facebook Page for the purpose of patient education

In opting out I acknowledge that:

- I have read the information above and have received an explanation about what clinical photographs will be taken and why.
- I am aware that this practice has a privacy policy on handling clinical photographs.
- I am not obliged to agree to clinical photography as part of my treatment but that in some circumstances my failure to do so may compromise the quality, nature or circumstances of the treatment that can be provided to me.
- I am aware of my right to access the information collected about me, except in circumstances where access might legitimately be withheld. I understand I will be given an explanation in such circumstances.
- I understand that my photographs will not be used for any purpose other than set out above without my consent.
- I consent to the use of my clinical photographs for the purposes set out above, subject to any limitations on the access or disclosure that I notify Melbourne Hand Surgery practice of.

Thank you for completing this form. Please save it (either by saving or by printing to PDF) and email to info@melbournehandsurgery.com. Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed.

If you have further questions please email us or phone us on (03) 9427 9596.