Dr Ryan Sommerville BSc, MBBS, FRACS (ORL) Provider No. 4691923W
Dr Thomas Slaughter BSc, MBBS, FRACS (OHNS) Provider No. 496129KK
Level 7, Watkins Medical Centre, 225 Wickham Tce, Spring Hill QLD 4000 Australia
Phone: + 617 3831 1448 Fax: +617 3831 1441
Email: admin@entsbc.com.au Web: www.entsbc.com.au

Dear: PATIENT / PARENT / GUARDIAN - Please complete all relevant information below

Patient's Title: Mr / Master / Mrs / Ms / Miss ***(please circle)***

First Name: _____ **Surname:** _____

Address: _____ **Suburb:** _____

Postcode: _____)___ **Date of birth:** ____/____/_____ **Home phone:** _____

Work Phone: _____ **Mobile number:** _____

Email Address: _____**Patient's Occupation:** _____

Patient's Medicare Number _____ **Ref no:** _____ **Expiry:** /

Pension #_____ **Type of Pension:** _____

DVA #_____ **GOLD/WHITE/BRONZE CARD** (please circle)

Health Fund Name: _____**Membership number:** _____ **Ref no:** ____

Next of kin name: _____**NOK Contact phone:** _____

Next of kin's relationship to patient: _____

Date of birth of the patient's parent/guardian *(If patient is under 18 years old):* ____/____/_____
(Required for accessing electronic Medicare rebates at our practice)
Medicare number of your guardian: _____**Ref No:** _____

Referral Information ***If you have a Medicare card you must provide us with a current doctor's referral in order to claim the maximum rebate back from Medicare.***

Name of your referring doctor: _____/ **Practice Location:**_____

Contact Number: _____

Name of your GP ***(if different to your referring doctor):*** _____ **Suburb:**_____

Contact number _____

_____

So we can ensure we are looking after your needs, please review and complete the following questionnaire (all records are kept strictly confidential):

MEDICATIONS

Please list all medications you are currently taking:

_____

_____

If you are currently taking any naturopathic remedies, please list (e.g. Garlic tablets, fish oil, vitamin E, St John's Wort etc.):

_____

ANY ALLERGIES: _____

_____

Have you any of the following? (Please circle your answer)

Heart problems	Yes	No	High Blood Pressure	Yes	No
Diabetes 1 or 2	Yes	No	Hepatitis: A B C D E, HIV	Yes	No
Asthma	Yes	No	Radiation treatment	Yes	No
Liver or Kidney problems	Yes	No			

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Ladies, are you pregnant? Yes No Due date ___/___/___ Breastfeeding: Yes No

Other medical conditions and previous operations:

_____ _____

_____ _____

Financial Consent

Payment at the time of consultation is required. We accept EFTPOS, Cash, or Credit Cards. Unfortunately we do not accept personal cheques, AMEX or Diners Card. **If the above information is correct, and you agree with our terms of payment, please sign below.**

Signature: _____Date:____/____/____

AUSTRALIAN PRIVACY PRINCIPLES (APP) POLICY 2014

COLLECTION AND USE OF PERSONAL INFORMATION

WE REQUIRE YOUR CONSENT TO COLLECT PERSONAL INFORMATION ABOUT YOU. PLEASE READ THIS INFORMATION CAREFULLY, AND SIGN WHERE INDICATED BELOW.

The ENT & Skull Base Centre follows the terms and conditions of privacy and confidentiality in accordance to the Australian Privacy Principles (**APPs**) as per schedule 1 of the *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth), forming part of the *Privacy Act 1988* ('the Act'). A copy of our Practice Privacy Policy is available to view upon request.

This information will in most circumstances be collected directly from you over the phone, via our new patient form and during face-to-face consultation. **In other instances, The ENT & Skull Base Centre may need to collect personal information about a patient from a third party source.**

This may include:

- other Specialist's, GP's involved in your care
- relatives

This will only be conducted if the patient has provided consent for The ENT & Skull Base Centre to collect his/her information from a third party source; or, where it is not reasonable or practical for The ENT & Skull Base Centre to collect this information directly from said patient. This may include where:

- the patient's health is potentially at risk and his/her personal information is needed to provide them with emergency medical treatment.
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I have read the above information and understand the requirements of The ENT & Skull Base Centre and myself in how to manage my personal information whilst attending The ENT & Skull Base Centre.

Signed_____ Date ____/____/____