ILLAWARRA ENT
HEAD & NECK CLINIC

# PATIENT DETAILS

| | |
|---|---|
| TITLE *(PLEASE CIRCLE)*: MISS / MRS / MS / MASTER / MR / MX / DR | |
| GIVEN NAME (AS ON MEDICARE CARD): | MIDDLE NAME: |
| SURNAME: | KNOWN AS: |
| ADDRESS: | |
| DATE OF BIRTH: | GENDER *(PLEASE CIRCLE)*: MALE / FEMALE / INTERSEX |
| HOME PHONE: | MOBILE: |
| EMAIL: | |

ARE YOU IN A PRIVATE HEALTH FUND FOR HOSPITAL COVER? YES / NO
PRIVATE HEALTH FUND NAME:

PRIVATE HEALTH FUND NUMBER:

HAVE YOU BEEN IN THE ABOVE HEALTH FUND FOR MORE THAN 12 MONTHS? YES/NO
IF NO; DATE JOINED:

IS ENGLISH YOUR FIRST LANGUAGE? YES / NO
IF NOT, DO YOU REQUIRE AN INTERPRETER? YES / NO
WHICH LANGUAGE DO YOU SPEAK?

WHO IS YOUR USUAL GP AND USUAL PRACTICE?

DO YOU HAVE ANY OTHER DOCTORS OR SPECIALISTS YOU WISH TO ADD TO YOUR CORRESPONDENCE LIST?
*(LIST DOCTOR AND LOCATION BELOW)*

DO YOU HAVE ANY ALLERGIES? YES / NO *IF 'YES' STATE BELOW*

| ALLERGY | REACTION |
|---|---|
| | |
| | |
| | |
| | |

## NEXT OF KIN/ALTERNATE CONTACT DETAILS (FOR ALL PATIENTS)

| | |
|---|---|
| *(PLEASE CIRCLE ONE)* PARENT / CARER / NEXT OF KIN | RELATIONSHIP TO PATIENT: |
| TITLE (PLEASE CIRCLE): MISS / MRS / MS / MASTER / MR / MX / DR | |
| FIRST NAME: | SURNAME: |
| BEST CONTACT PHONE NUMBER: | |

## WORKERS COMPENSATION CLAIM DETAILS *(ONLY IF APPLICABLE)*

| | |
|---|---|
| EMPLOYER: | OCCUPATION: |
| INJURY: | DATE OF INJURY: |
| LOCATION OF INJURY: | |
| HOW DID THE INJURY OCCUR: | |
| INSURANCE COMPANY: | DATE OF CLAIM: _ _/_ _/_ _ _ _ |
| CLAIM NUMBER: | CASE MANAGER: |
| | |

ILLAWARRA ENT
HEAD & NECK CLINIC

Prof. Stuart G MacKay BSc (Med) MBBS (Hons) FRACS
Dr Stephen J Pearson MBBS BSc (Med) Hons 1 FRACS
Dr Daniel S Cox MBBS FRACS (ORL HNS)
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Suites 1&2 / 8-10 Victoria Street
WOLLONGONG NSW 2500

Phone: 02 4226 1055
Email: reception@illawarraent.com.au

PATIENT NAME: _____

PATIENT DOB : ____ /____ / _____

## TO WHOM IT MAY CONCERN

As a patient *(or parent/legal guardian of the patient)* of Illawarra ENT, Head & Neck Clinic, I agree to the following:

1. Release of any previous medical reports and results to the Doctors' at the above mentioned clinic.
2. Collection, use and disclosure of clinical photographs.
3. Disclosure to other health care professionals, including treating doctors, specialists and allied health providers outside of our practice. This may occur through referrals to other health professionals or pathology/radiology etc and in the reports or results returned to us following referrals.
4. Disclosure to other doctors in the practice, locums etc attached to the practice for the purpose of patient care and teaching or for research and quality assurance activities to improve individual and community health care and practice management.
5. I am aware that the maximum fee charged is $470.00
   *(this includes the minimum consultation fee of $220 plus any procedures/tests)*
6. If you hold a Pension or Health Care Card from Centrelink the maximum fee is $220.
7. Correspondence will only be directed to referral practitioner and relevant clinicians.

*PLEASE NOTE:*
*We require 24 hours' notice of inability to attend an appointment.*
*If we do not receive 24 hours' notice a non-attendance/late cancelation fee may be charged at a rate of 50% of the expected consultation fee.*

_____ _____
SIGNATURE DATE

_____
PRINT NAME (of person signing)

PLEASE COMPLETE BOTH PAGES