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sunshine coast
cardiology

PATIENT REGISTRATION INFORMATION

Title		First Name	
Surname			
Middle Name			
Known As		Date of Birth	
Address			
Suburb		Postcode	
Postal Address (if different)			
Home Phone		Work Phone	
Mobile		Email	
Next of Kin Name/Phone			
General Practitioners Name			

Medicare Card no.		Position	
Expiry date / valid to			
Private Health Fund			
Membership No. (Not card number)			
DVA card number:			

Please read this consent form carefully, if you agree please sign where indicated below.

Sunshine Coast Cardiology requires your consent to enable us to collect personal information and any relevant medical history. We require this information to assist us in providing you with quality health care.

I give my permission for my personal health information to be used for administrative purposes to assist in the running of Sunshine Coast Cardiology, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this medical Practice. This may occur, for example, through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

I understand by signing the form below that the Practice is authorized on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

PRINT NAME OF PATIENT: .... DATE: ....

SIGNATURE OF PATIENT: ....

PARENT / GUARDIAN (IF UNDER 18 YEARS) ....

To send this form to us in advance –
Fax: 07 5444 0098
Mail: PO Box 1973 Buderim Qld 4556
Alternatively, bring this completed form with you on the day of your consultation.