# Patient Registration- Mr Charles Han

**Title: ____First name:________________________ Surname:________________________ Date of Birth ___/___/_____**

**Address:____________________________________________Suburb:_________________________Post Code:________**

**Phone:_________________ Mobile: _____________________ Emai:_____________________@_________________**

**MEDICARE NUMBER: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____**

**Reference number:** ***(Number that appears next to your name)*** **_____ Expiry: _____ /______**

**Private Health Fund:_____________________________ Member Number: ________________________**

**Have you had Private Health Insurance for longer than 12 months?** ***YES / NO***

**Do you receive the Aged Pension?** ***YES / NO CRN*** **___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___**

**Occupation:_________________________________________________ Marital Status___________________________**

**Your USUAL GP if different to your referral_______________________________________________________________**

**How many doses of the Covid Vaccination have you had? (Please circle)** ***1 2 3***

**Emergency Contact Name: ____________________ Phone:_________________ Relationship:___________________**

**Do you take any blood thinning or anti coagulating medication? (i.e. Aspirin, Warfarin)** ***YES / NO / NOT SURE***

**Daily Consumption of: Coffee / Tea________ cups Alcohol__________ glasses Tobacco___________**

**Do you currently have or have suffered from the following?**

| | |
|---|---|
| ○ **Heart Condition** | ○ **Epilepsy** |
| ○ **Respiratory Issues** | ○ **Thyroid Issues** |
| ○ **Stroke** | ○ **Hepatitis, HIV** |
| ○ **Thrombosis, Clotting, DVT** | ○ **Anaemia** |
| ○ **Diabetes** | ○ **Other** |

***Privacy Statement:***

**Mr Han collects your information for the primary purpose of providing quality healthcare. He asks you to provide him with your personal details and a full medical history so that he may properly assess, diagnose , treat and be proactive in your healthcare needs. He may use the information you provide for administrative purposes in running his medical practice, including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used in research, quality assurance or educational purposes.**

***Payment Agreement:***

**Please advise reception if you are unable to pay your account at the time of consultation. Patients who do not pay their account after their consultation are advised that payment is due within 14 days. Accounts not paid within 14 days may incur a late fee. Mr Han uses a Debt Recovery Service for overdue accounts. Any charges incurred for this service will be passed onto the patient.**

***I consent to the handling of my information by this practice for the purpose set out above. I understand my obligation with regards to payment of my account.***

**Signature_____________________________________________________________ Date ____/____/________**