MACCS medical group
Melbourne Allergy Centre & Children's Specialists

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PATIENT REGISTRATION FORM

1. PATIENT DETAILS				
Title:	Address 1:		DOB:	Age:
First Name:	Address 2:		Gender:	
Surname:	Suburb:		Home phone:	
School / Creche:	State:	Postcode:	Work phone:	
Year Level:			Mobile Phone:	

2. PARENT / GUARDIAN DETAILS		
Parent 1	**Parent 2**	**Account Holder (if not Parent 1 or 2)**
First Name:	First Name:	First Name:
Surname:	Surname:	Surname:
Occupation:	Occupation:	Occupation:
*DOB:	*DOB:	*DOB:
Email:	Email:	Email:
Mobile	Mobile:	Mobile:

3. MEDICARE DETAILS															
Card Number											Patient Position		Parent Position		

Do you have private health insurance? ☐ No ☐ Yes ➔ If Yes, Name of Fund:
Membership Number:

Referring Dr Details	**GP's Details:** ☐ Same as referring doctor ☐ Different *(please give details below)*
Name:	Name:
Address:	Address:
Phone:	Phone:
Provider no:	Provider no:

4. How did you hear about MACCS?

Please tick the most applicable:

☐GP Referral ☐Internet Search ☐School ☐ Friend / Family ☐ Maternal Nurse ☐ *Other* _____

5. PRIVACY INFORMATION AND CONSENT

Please carefully read the following information about privacy issues and fees structure, then sign this form where indicated below.

Privacy issues

The main reason why information is collected by this practice is so that we can assess, diagnose and treat your illness and to be proactive in your health care needs. This means that we will use the information you provide in the following ways:

1. Administrative purposes in running the medical practice
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in reports or results returned to us following the referrals.

Patient/guardian's acknowledgement

1. I have read this form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.
2. I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.
3. I am aware that I have the 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 these circumstances.
4. 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.
5. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.
6. I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not at first understand.

Fees structure

I understand that the cost of consultation is above the Medicare schedule fee, which means that I will incur an out-of-pocket expense. I have been shown a copy of the fee structure in the patient appointment letter. I agree to pay this account at the time of consultation.

Signed:	**Name:**	**Date:**

** DOB is collected for the purpose of Medicare Online claiming*