Adelaide Hills O&G
Dr Melanie Johnson
Dr Heather Waterfall

Phone: (08) 7123 4137
Fax: (08) 8485 1917

89 Wellington Road
Mount Barker SA 5251

admin@adelaidehillsoandg.com
adelaidehillsoandg.com

Registration Form

Title _____ Date of Birth _____
Given Name _____
Preferred Name _____
Surname _____

Address _____ Suburb _____
_____ Postcode _____

Mailing Address _____ Suburb _____
(if same as above leave blank) _____ Postcode _____

Phone:
Home _____ Email _____
Mobile _____ Occupation _____
Work _____

Do you consent to receive correspondence via email Yes or No (please circle)
Do you consent to receive correspondence via SMS Yes or No (please circle)

Medicare number _____ Reference ____ Expiry _____
Concession _____ ____ _____
DVA _____ ____ _____

Private Health Insurance Yes or No (please circle) Hospital cover Yes or No (please circle)
Fund Name _____
Member Number _____ Obstetric cover Yes or No (please circle)

Emergency Contact Name _____
Surname _____
Phone _____
Relationship _____

GP Name _____
(if different to referring Doctor) Practice _____

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Privacy consent statement

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- 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 the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement
- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

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.

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 that I notify this practice of.

Financial Consent Statement

I am aware there will be a fee above the Medicare rebate to be seen at Adelaide Hills O&G and agree to pay the account in full on the day of service. A procedural estimate of fees will be provided where appropriate.

Signed _____

Date _____