Professor Roger KA Allen Registration Form

Please complete both sides and return to our receptionist. ***PLEASE PRINT CLEARLY***

Patient Details

Title: (Mr/Mrs/Miss/Ms/Rank/Other (please specify): ..... Surname .....

Given Names: ..... Gender recorded at birth: M / F Date of Birth: ..../...../.....

Residential Address: .....

Suburb: ..... Postcode: .....

Postal Address (if different from residential): .....

Telephone: (Home) ..... (Business) .....

Mobile Number: ..... Email: .....

We regularly send SMS reminders for pending appointments for your convenience. We sometimes also send results or medication notifications. Please check the box if you **DO NOT** want these to be sent to you. ☐

Knowing your cultural background can help us provide healthcare that meets your individual needs
Are you of Aboriginal or Torres Strait Islander origin?

No Yes Aboriginal Yes Torres Strait Islander Both Aboriginal & Torres Strait Islander

Other Cultural Background e.g. (Mediterranean, Asian, African): .....

Occupation: .....

Place of Employment: .....

Have you seen Dr Allen previously as an inpatient/private patient? Yes / No

If yes, where? ..... Date: .....

Marital Status (please circle): MARRIED SINGLE DIVORCED DE-FACTO WIDOW(ER)

COVID-19 Vaccine status: Yes / No Date of most recent booster: / /

Booster Type ie: Pfizer / AstraZeneca / Moderna / Other: .....

Height: ..... Weight .....

Medicare, DVA & Private Health Insurance

Medicare Number: .....

Card reference number (beside your name on card) : ..... Medicare card expiry date .....

DVA Card Number: ..... GOLD / WHITE Disability:.....

Do you currently have private health insurance? Yes / No

Name of Fund: ..... Membership Number: .....

Next of Kin or Emergency Contact

Title: (Mr/Mrs/Miss/Ms) Full Name:.....

Relationship to Patient: .....

Telephone: (Home) ..... (Mobile or Work) .....

PLEASE TURN OVER.....

Referral Details – (*Please note specialist referrals are valid for only 3 months from date of initial use)*

Referring Doctor: .....

Address: .....

Tel: ..... Fax: .....

Family Dr/GP: (if different from referring doctor) -.....

Address: .....

Provider Number:..... Telephone: .....

Please list **any other doctors** you see who should be kept informed of your consultations with Professor Allen

Name: ..... Specialty:..... Suburb:.....

Name: ..... Specialty:..... Suburb:.....

Name: ..... Specialty:..... Suburb:.....

Name: ..... Specialty:..... Suburb:.....

Medicolegal Patients ONLY

Name of solicitor handling your case: .....

Legal Firm:..... Address: .....

Telephone: (.....)..... Claim Number: .....

The main purpose for collecting your information is to provide the best possible health care. A photo is required for chart identification and will not be used for any other purpose. We must also comply with laws that require collection or disclosure of personal information about you. Please sign below to indicate you consent to your information being released if/when relevant to other medical practitioners who may be involved in your current treatment plan, for medical research or clinical audits. Please consent to communication via text message regarding appointment confirmations and basic results. Confidentiality is closely guarded. Information will not be used for any other purpose.

Signature: ..... **Date:** ..... / ..... / .....

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Thoracic & Sleep Disorders Physician

Prof. Roger K A Allen
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ABN 53 006 461 730

Provider: 044285EY

After Hours
0417 629 816

reception@sarcoidosis.com.au

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Privacy Consent Form of Professor Roger Allen

Dear Patient,

In accordance with the Privacy Act, we require your consent to collect your personal information. Please read the following Information carefully and sign where indicated below.

We collect your personal information in order to provide you with the best possible health care. We require your personal details and full medical history, enabling us to assess, diagnose and treat you fully, and be proactive in your health care.

Your information will be used in the following ways:

- Administration of this medical practice.
- Billing, including compliance with the requirements of Medicare Australia.
- Disclosure to others involved in your health care, including treating doctors and specialists.
- Disclosure to others for medical defence purposes if necessary, upon your signing of relevant third party documentation.
- Disclosure to insurers, employers or solicitors where applicable.

At this stage we have chosen not to register as an organisation for the My Health Record government program so will be unable to access your My Health Record. This may change in the future.

I have a My Health Record (please circle) Yes No

I (name) _____ have read and understand this form and I understand that this practice must comply with laws that govern the collection of data of or disclosure of personal details regarding my care.

I understand that I am under no obligation to provide any information requested of me, but that my failure to do so may compromise the quality of treatment and health care which will be given to me.

I am aware that I have the right to access my personal information, except in circumstances where access might legitimately be withheld. I understand that I will be given an explanation in these circumstances. If I require any content from my medical chart, I will inform the practice in writing to identify myself.

I consent to allowing this practice to collect, use and disclose my personal information for the purposes set out above, subject to any limitations to access or disclosure of which I notify this practice.

I consent to the disclosure of information regarding my appointments and outstanding accounts being given to the next of kin provided by myself, unless I have stated otherwise.

Signature: _____ Date: _____

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Thoracic & Sleep Disorders Physician

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Attn:

I (name), _____ *DOB: / /*

Hereby consent for Dr Roger Allen to request any relevant medical information and history about me from my general practitioner and other healthcare professionals involved in may care.

Signed: _____

Date: / /