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……..) Surname……

Given Names: …….. 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. ☐

Ethnicity: ……

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)

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: …… Spouse? ……

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: …… / …… / ……

RADIOGRAPHIC MATERIALS

Dr Roger Allen prefers to see actual films of your x-rays and you will need to bring these (past & present) with you to your appointments. We do not store x-rays/scans for any period of time exceeding three months. It is essential that you keep the scans in your possession at all times.

I hereby understand that any x-rays or scans left in our possession after twelve months, will be destroyed, without prior notice.

Signature: …… Date: …… / …… / ……