- Dr Emma Hiscutt
- Dr Suresh Sivanesan
- Dr Jason Tye-Din
- Dr Amanda Saracino
- Annabel Mackenzie

Central Melbourne Specialists
Office 401, Level 4 North Office
Aurora Melbourne Central
37 Little Latrobe Street
Melbourne VIC 3000
Phone: 03 8417 9900
Fax: 03 9415 1069
Email: admin@thecms.com.au

Patient Registration & Consent Form

Ms Miss Mrs Mr Dr Prof Please circle	First Name:	Surname:
Street Address:		
Suburb:		Postcode:
Postal Address: If different from above		
Date of Birth: / /	Home Phone:	Mobile Phone:
Email Address:		Occupation:
Emergency Contact Name:		Relation:
Emergency Contact Phone Number:		
Usual GP Name: (if different from referring doctor)		

Medicare Card Number: __ __ __ __ __ __ __ __ __ __ Ref: ___ Expiry: ____ / _____

Health Care Card/Pension Card/DVA Card Number: __ __ __ __ __ __ __ __ __ __ Expiry: ____ /____ / _____

For gastroenterology patients only

Private Health Insurance Fund Name: _____ *Member No:* _____

If patient is under 18 or not responsible for the account, the following details are required for Medicare purposes

Account Holder's Name: _____ Date of Birth: ___ / ___ / _____ Phone: _____

Medicare Card Number: __ __ __ __ __ __ __ __ __ __ Ref: ___ Expiry: ____ / _____

Privacy Consent

Federal Privacy Law requires that fully informed voluntary consent be obtained for the collection of health information. Your personal information and medical history is collected, documented, stored securely and may include photographic images of your skin. This information is used for the following purposes:

- to assess, diagnose, treat and be proactive in your healthcare needs;
- for administrative and billing purposes - including Medicare, Workcover and Health Insurance Commission requirements;
- disclosure to other healthcare providers involved in your care including treating doctors and specialists outside of this practice through referral to other doctors or for medical tests;
- retrieving medical history from your other health care providers.

I have read the information above and understand the reasons why my information must be collected.
I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise my own healthcare and treatment.
I consent to the handling of my information as outlined above, subject to any limitations on access or disclosure of which I may notify this practice.
I understand that I may withdraw my consent at any time by notifying this practice in writing.

I understand that consultations are not bulk-billed, not payable by private health insurance and are payable on the day of consultation. I understand that if there is a need for a procedure or treatment, there will be an additional fee payable for these and I will be made aware of out-of-pocket costs prior to my procedure.

Patient Name: _____ Signature: _____ Date: _____