

# Confidential Registration

Please fill in this form and bring it to your initial consultation.

Title:	Surname:	First Name:
Address:		
Suburb:	State:	Postcode:
Telephone: [H]	[W]	[M]
Email:		
Date of Birth: DD/MM/YYYY	Occupation:	
Family Doctor:	Telephone:	
Address:		
Suburb:	State:	Postcode:
Referring Doctor:	Telephone:	
Address:		
Suburb:	State:	Postcode:
Medicare No.:	No. on card:	Expiry:
Veterans Affairs No.:	Health Fund:	Pension No.:
Member No.:		
How did you hear about us? <input type="checkbox"/> Friend <input type="checkbox"/> Advertising <input type="checkbox"/> Referring Doctor <input type="checkbox"/> Website <input type="checkbox"/> Other:		
Do you have or have had any of the following? <input type="checkbox"/> Anaesthetic problems <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bad scars <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Blood clots <input type="checkbox"/> Cold sores <input type="checkbox"/> Diabetes <input type="checkbox"/> Healing problems <input type="checkbox"/> Heart problems <input type="checkbox"/> Hepatitis <input type="checkbox"/> High blood pressure <input type="checkbox"/> HIV/AIDS risk <input type="checkbox"/> Psychiatric treatment <input type="checkbox"/> Spinal/neck problems		
List current illnesses:		
List current medications: NB: Include - aspirin, cortisone / steroids, anti-inflammatory, warfarin, herbal products and over-the-counter preparations.		
Do you smoke?	How many per day?	Alcohol intake?
Allergies:		
Previous operations:		

Declaration	
I understand clinical photographs may be taken.	
I give permission for clinical photographs to be used for medical education:	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for clinical photographs to be used for patient education:	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for these details to be used in communication with other health professionals involved with my care:	Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for Dr Kippen to contact me via post or email:	Yes <input type="checkbox"/> No <input type="checkbox"/>
I have read the Patient Privacy Policy document:	Yes <input type="checkbox"/> No <input type="checkbox"/>

Signature	
	DATE / /

**All correspondence to**  
Suite 204, Level 2  
20 Bungan Street  
Mona Vale NSW 2103

**Mona Vale**  
Suite 204, Level 2  
20 Bungan Street  
Mona Vale NSW 2103

**Brookvale**  
Suite 119, Level 1  
20 Dale Street  
Brookvale NSW 2100

**Wahroonga**  
Suite 507, San Clinic  
Sydney Adventist Hospital  
185 Fox Valley Road  
Wahroonga NSW 2076

## Patient Privacy Act

As a result of new privacy laws introduced by the Government, this office requires you to read this sheet regarding your personal and medical information and then sign to say you have read and agree with the statement.

Your files contain the following information:

- Personal details (name, address, date of birth, Medicare number and & health details)
- Your medical history
- Notes made during the course of your medical consultation
- Referrals to other Health Service Providers
- Results and reports received from other Health Service Providers

This information is provided by you or arises as a consequence of information provided by you.

It may be necessary for us to obtain copies of reports such as x-rays, pathology and correspondence from other Medical Practitioners or Health Professionals, or confer with Surgical Colleagues or your General Practitioner regarding your medical treatment.

Due to changes in the Privacy Act, it has become necessary for us to obtain written consent from each patient in our practice to obtain these records. Please note, Medical records cannot be released without your consent, except when they are required under law such as a subpoena.

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