Please print page 3 & 4 and bring completed to your appointment

Patient Name: ______________________________**Mobile**: __________________________

Home Ph: _________________ **Work Ph**:_______________________

Home Address:____ **State:** _________**Postcode**:_________

Postal Address (if different to above) _____________________________ **State**: _________ **Postcode:** ________

Medicare Card # _________________**Patient Number on Card** ____ **EXP**___/____

If applicable - Pension or DVA Card # ___________________________ **EXP**___/____

Email: _______________________________

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Private Hospital Cover o Yes o No Fund Name: ____________________Member Number____________________

Date Covered Commence ____/____/_____

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For children:

Parent Medicare Card # _________________ **Parent Name:** _________________________

Parent Number on Card ____ **EXP**___/____ **Parent Date of Birth:** ___/___/____

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Privacy: Our practice complies with State and Federal privacy legislation.

Please read the privacy policy on our website at www.clancy-ent.com.au under the Appointments tab. if you would like a hard copy of our policy, please speak to our reception staff.

Patient Emails: We sometimes need to communicate further information to our patients regarding surgeries or informed financial consent. Do you consent to receiving information in this way? o **YES** **o NO**

SMS: Are you happy to receive communication from us via SMS? o **YES** **o NO**

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Overdue Accounts: In the event of an account being outstanding, you will be liable for all debt collection and legal costs incurred by Dr Clancy's practice on an indemnity basis.

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Photographs:

Photographs may be taken during your consultation and during your surgery. These photographs are stored securely in your medical record and may be used for teaching purposes. All photos used for teaching are de-identified.

o **I consent** to my photos being used for teaching o **I DO NOT consent** to my photos being used for teaching

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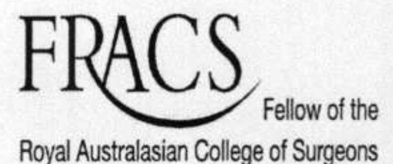
Communication:

After your consultation Dr Pratap will send a letter to your referring doctor. Please indicate if you would like a copy of this letter to be sent to another doctor: General practitioner: ___________________Other doctor: _____________________

** Copies of correspondence from our practice sent to your GP or other specialists are available upon request.

Name ___________________________________ **Signature:** __________________________**Date:**__/__/__



Patient Name: ______________________________ **Date of birth**: ___/___/___

Gender: o Male o Female o Gender Diverse

Please circle below relationship to yourself-

Partner/Emergency contact/Next of kin:_____________________________ **Contact Ph #:**____________
Do you consent to this person receiving information about your health? o Yes o No

Do you have a Medical Power of Attorney o No o If Yes - Name ____________Contact Ph # ____________

For children: Mother's name__________________ Father's name ________________
I live with o Mother o Father o Shared Care

Main concerns:

Please list any questions that you have for Dr Clancy today:

Current Medications:	Major health problems:	Please tick any that apply
		☐ Pacemaker or defibrillator ☐ Heart valve replacement ☐ Bleeding disorder ☐ DVT/pulmonary embolus ☐ Diabetes ☐ Smoker/Ex-smoker
Allergies:	**Past operations:**	☐ Reflux/Ulcers ☐ Epilepsy/seizures ☐ Osteoporosis ☐ Asthma ☐ Glaucoma ☐ Sleep Apnoea

For Doctor and Nursing Staff to complete:

Height: ______**cms** **Weight** ______**kgs**

ASOHNS MEMBER | THE AUSTRALIAN SOCIETY OF OTOLARYNGOLOGY HEAD AND NECK SURGERY

FRACS Fellow of the Royal Australasian College of Surgeons