

carlos chung

open and endovascular neurosurgeon
provider no. 273487DJ



**Melbourne
Institute of
Neurovascular
Diseases**

Comprehensive | Informative | Patient Focused | Quality Care

Patient Registration Form

Personal Details

Mr Mrs Ms Miss Dr Prof Other _____

Surname: _____ Given name: _____

Date of Birth: ____/____/____ Occupation: _____

Address: _____

Suburb: _____ Postcode: _____

Telephone: (H) _____ (B) _____ (Mob) _____

Email: _____

Next of Kin:

1. Name: _____ Relationship: _____

Telephone: (H) _____ (B) _____ (Mob) _____

2. Name: _____ Relationship: _____

Telephone: (H) _____ (B) _____ (Mob) _____

Medicare: _____ Ref number _____ Expiry _____/20 _____

Aged Pension Card Card No _____ Expiry _____/20 _____

Veterans Affairs? White/Gold Card No _____ Expiry _____/20 _____

Private health insurance? YES/NO

Name of Fund _____

Membership No _____

**Please note Mr Chung does not see TAC or Workcover patients*

Referring Doctor Details

Name: _____ Ph: _____

Address: _____

Suburb: _____ Postcode: _____

GP Details (if different to above)

Name: _____ Ph: _____

Address: _____

Suburb: _____ Postcode: _____

po box 668 carlton south vic 3053

ph 03 9419 5597 or 1300 1 BRAIN fax 03 9923 6928
contact@cerebrovascular.com.au www.cerebrovascular.com.au
abn 64 606 377 080

Medical History

Please indicate if you suffer or have suffered from any of the following:

Hypertension (high blood pressure)	Y/N	Diabetes	Y/N
TIA (mini stroke)	Y/N	Stroke	Y/N
Myocardia infarction (heart attack)	Y/N	Angina	Y/N
Epilepsy	Y/N	Asthma /COPD	Y/N
Deep vein thrombosis (DVT)	Y/N	Pulmonary Embolism (PE)	Y/N
Bleeding disorder	Y/N	Renal (kidney) impairment	Y/N
Other			

Previous Surgical Operations/Interventions:

Operation/Intervention: _____ Year: _____

Operation/Intervention: _____ Year: _____

Operation/Intervention: _____ Year: _____

Current Medications/Over the Counter Medicines/Herbal/Vitamins:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Allergies: _____

Do you take any of these blood thinning medications?

Aspirin (Cartia® Cardiprin®)	<input type="checkbox"/>	Clopidogrel (Plavix® Iscover®)	<input type="checkbox"/>
Prasugrel (Effient®)	<input type="checkbox"/>	Ticagrelor (Brilinta®)	<input type="checkbox"/>
Ticlopidine (Tiodene®)	<input type="checkbox"/>	Dipyramdole (Asasantin®)	<input type="checkbox"/>
Warfarin (Coumadin® Marevan®)	<input type="checkbox"/>	Apixaban (Eliquis®)	<input type="checkbox"/>
Dabigatran (Pradaxa®)	<input type="checkbox"/>	Rivaroxaban (Xarelto®)	<input type="checkbox"/>
Ginseng	<input type="checkbox"/>	Ginkgo Biloba	<input type="checkbox"/>

Tobacco Smoking:

Never Smoked Previous Smoked Last smoked _____

Current Smoker How many per week? _____ How long? _____

Settlement of the account on the day of consultation is required.
Payment can be made with Mastercard/Visa/EFTPOS/Cash.
Initial Consultation is \$300.00 (aged pension \$200.00) Medicare rebate is \$110.20
Review Consultations are \$180.00 (aged pension \$120.00) Medicare rebate \$72.75

Privacy Statement and Participation in Research Consent Forms

Melbourne Institute of Neurovascular Diseases (the practice) would like to provide you with sufficient information on how your personal health information may be used or disclosed, and record your consent or restrictions to this consent.

Information about you is very important to us and we shall treat it with care and respect. At all times, we are required by law in pursuant of the Privacy Act 1988 and Australian Privacy Principles (APPs) to ensure details about you remain confidential.

Our doctors and staff are required to sign a confidentiality agreement at commencement of working at the practice, and are also given training in this area at induction, so that they understand how to protect your privacy.

The information we ask and collect may be personal but not having it may restrict our capacity to provide you with the standard of medical care that you expect.

Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: Medicare and health insurance details, data collected from observations and conversations with you, notes from consultations, medical test results and details obtained from other health care providers (e.g. GP/specialist correspondence) and/or third parties. Your health information can also include information that you provide to us regarding your social and family history because it is relevant to your ongoing health management.

The reason why we collect information about you is so we can provide you with quality health care, we may also use the information you provide in the following ways:

- Follow up reminder/recall notices for treatment and preventive healthcare, and appointment reminders to phone numbers provided by you. You may inform us if you do not want voice messages relating to appointments left on phones. When you provide us with a mobile number, we accept this as your consent to use this to deliver SMS appointment reminders, or leave messages, unless you tell us otherwise.
- For use when seeking treatment by other doctors in this practice.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- For practice accounting procedures and the collection of professional fees, both internally and via debt collection services. Only name and contact details and the outstanding invoices will be disclosed.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating doctors and other professionally trained and qualified persons eg. Nurses and Practice Managers.
- For legal related disclosure as required by a court of law, child protection agencies or in response to a subpoena.
- For third party requests by organisations such as insurance companies and lawyers. Such requests can occur when you are making an insurance claim on a policy, when you are applying for a new policy or have engaged a legal representative to act on your behalf. Such disclosure is only made when you provide an authorisation (may be an electronic signature) to the insurance company or lawyer for us to release information. Often such requests are for the whole medical record and may include information that is not directly related to your claim.
- Workers Compensation matters. When you have a claim under workers compensation, it is a legal requirement that any treating doctor who writes WorkCover medical certificates for you must provide information when requested, to the Workers Compensation Organisation - this may be done verbally, in a written report or with provision of part or whole medical records.
- For the purposes of research only where non-identifiable information is used. The research conducted may be published in scientific journals, which is distributed worldwide and goes mainly to doctors but is seen by many non-doctors, including journalists. The Information will be published without your name attached and every attempt shall be made to ensure your anonymity, however, complete anonymity cannot be guaranteed. It is possible that somebody somewhere - perhaps, for example, somebody who looked after you in hospital or a relative - may identify you. You may revoke consent at any time before publication, but once the Information has been committed to publication ("gone to press") it will not be possible to revoke the consent.
- To allow medical students and staff to participate in medical training/teaching using only non-identifiable information.
- For disease notification as required by law.
- Where you are unable to act on your own behalf due to a health condition, we may need to discuss your health information with relatives or emergency contacts, in order that you are provided with appropriate care.
- If you interact with us via our website, we will use personal information that you give to make an appointment when you use the online appointment facility, or we will collect your email address, in order that we can respond to you.

Patient Acknowledgement

- I have read this form and understand why collecting information about me is necessary.
- I acknowledge that a member of staff was available to clarify any aspect and a copy of the privacy policy is available at my request.
- I give my permission for my personal health information to be collected, used and disclosed as described above, I understand only my relevant personal health information will be provided to allow the above actions to be undertaken.
- I understand I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing without giving any reason, and without my medical care or legal rights being affected.
- Please note the following restrictions to this consent that I wish to apply at this point:

Signature: _____ Name: _____ Date: _____

PRACTICE USE ONLY: (Staff Signature) _____