Mr Patrick Walsh
MBBS, FRACS
35 Chapel Street
St Kilda VIC 3182
Ph: (03) 9521 7708
Fax: (03) 9521 7703
www.drpatrickwalsh.com.au

DR PATRICK WALSH
EAR, NOSE & THROAT

Patient Registration Details

Title:	**Given Names:**	
Surname:		**Date Of Birth:**
Address:		
Postal Address (if different):		
Ph: (H)	**Ph:(W)**	
Ph: (M)		
Email Address:		
Referring Doctor:		
Usual GP (if different):		
Medicare No:	**Ref No:**	**Exp:**
Private Health Fund:		**Membership No:**
Please Circle: **Hospital**	**Extras**	**Both**
Pension Card No:		**Exp:**
Veteran's Affairs Card No:		

Consultations:

This practice does not bulk bill. A fully paid invoice can be submitted to Medicare for a rebate. Accounts must be settled on the day of consultation. Payment methods include: cash, cheque, EFTPOS or credit card.

Fees:
Please contact our rooms on (03) 9521 7708 to inquire about our fees.

Operations
With respect to operation fees, they are determined by Mr Walsh. Patients will receive a comprehensive quote detailing their out of pocket costs. Fees for operations are payable in advance.

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Patient data form and Privacy Laws

Patients are now required to complete a data form. The collection of this information is essential for clinical and administrative purposes. All collected information will be held and disclosed in compliance with the Health Records Act (VIC) 2001. All patients are kindly asked to carefully read and sign CONSENT for COLLECTION OF PERSONAL INFORMATION.

I GIVE AUTHORITY TO THIS MEDICAL PRACTICE TO COLLECT AND HOLD MY PERSONAL INFORMATION IN ACCORDANCE WITH THE PRIVACY ACT. (Health Records Act (VIC) 2001)

I AM AWARE THAT THIS INFORMATION MAY BE SHARED WITH OTHERS INVOLVED IN MY HEALTH CARE, INCLUDING TREATING DOCTORS, SPECIALISTS, PATHOLOGY, RADIOLOGY AND AUDIOLOGY CLINICS AND ALIKE OUTSIDE THIS MEDICAL PRACTICE.

Please note: Due to privacy issues we do not participate in conversation regarding a patient's medical condition over email or text messages.

I UNDERSTAND THAT I AM NOT OBLIGED TO PROVIDE ANY OF THE INFORMATION REQUESTED OF ME, BUT THAT MY FAILURE TO DO SO MIGHT COMPROMISE THE QUALITY OF HEALTH CARE PROVIDED TO ME.

(for patients 18y or above please fill out below)

Patient name.....

Patient signature.....

Date.....

OR **(for patients under 18y Parent/Guardian to fill their details below in order to process Medicare online claim)**

Parent/Guardian Name.....

Date of birth.....

Signature.....

Medicare no.....Ref No.....

Today's Date.....