Northern Beaches
IMMUNOLOGY & ALLERGY

Suite 75, 23 Narabang Way Belrose NSW 2085 ph 02 9450 0687
www.nbia.com.au fax 02 8209 4882

NEW PATIENT INFORMATION

PATIENT DETAILS			
Title	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Prof		
Surname		Date of Birth	/ /
First Name		Preferred Name	
Middle Name		Home Phone	
Mobile		Work Phone	
Street Address		State	
Suburb		Postcode	
Email Address			
Medicare No.	___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___	Expiry	/
Medicare Reference No.	(next to patient's name in Medicare Card)		
DVA Card No.	___ ___ ___ ___ ___ ___ ___ ___	Expiry	/
DVA Card Type	☐ Gold ☐ White ☐ Orange		
I agree to communicate and receive necessary reports/documents requested by email ☐ (please tick)			
How did you hear about us? ☐ Referral ☐ Google ☐ Friends ☐ Family ☐ Other:			
SECONDARY / EMERGENCY CONTACT (Other than the mobile above)			
Name		Relationship	
Mobile			
MEDICARE ACCOUNT HOLDER'S DETAILS (if not patient)			
Name			
Date of Birth	/ /	Relationship	
Medicare No.	___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___	Expiry	/
Medicare Reference No.			

REFERRAL DETAILS (GP's referral - valid for 12mo, Specialist's referral - valid for 3mo)	
Referring Doctor	☐ Specialist ☐ GP
Doctor's Specialty	(if different from above)
Usual GP	(if different from above)
Usual GP's Phone#	

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP? If so, please list them (list continues to page 2):

Doctor's Name	Practice Name/Address	Phone#
Doctor's Name	Practice Name/Address	Phone#
Doctor's Name	Practice Name/Address	Phone#

Continued from page 1

Doctor's Name	Practice Name/Address	Phone#
Doctor's Name	Practice Name/Address	Phone#
Doctor's Name	Practice Name/Address	**Phone#**

CONSENT TO COLLECT PATIENT INFORMATION & PAYMENT

Northern Beaches Immunology & Allergy collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses, and be pro-active in your health care. We will also use the information you provide in the following ways:

1. Administrative purposes in running our medical practice;
2. Billing purposes and compliance with Medicare and Health Insurance Commission requirement;
3. Medicare assignment of benefit to doctor and claiming patient's rebate;
4. Hospital inpatient and outpatient services claim
5. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice, electronic prescription delivery service/s
6. If I have a My Health Record, it may be accessed during my treatment and information may be uploaded by registered health care practitioners at the practice

By signing this form I acknowledge:

- 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 might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand that I will be given an explanation in these circumstances.
- if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.
- I understand that if my information is to be used for any purpose other than set out above, my further consent will be sought.
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.
- I understand that if I wish to obtain a copy or access to my medical records the request must be made in writing and a cost m0ay be incurred.
- I consent for the assignment of Medicare benefit to doctor for all video or telephone consultations unless I am privately billed with gap.

Please note that FULL PAYMENT is required ON THE DAY of your consultation.

I declare that I understand that the payment for the consult and all tests is required in FULL on the day of the appointment.

Name : _____

☐ Patient ☐ Parent ☐ Carer ☐ Legal Guardian

Signed: _____ Date: _____/ _____/ _____

Please sign. Do not type in your name