PATIENT INFORMATION

Dr Michael Ee
209 Melbourne Street
North Adelaide SA 5006
Phone: 0499 919 968
Fax: 08 8125 3886

PATIENT SURNAME:

PATIENT FIRST NAMES: KNOWN AS

PATIENT - DOB: Male Female Other

ADDRESS:

POST CODE:

POSTAL ADDRESS:

POST CODE:

HOME TELEPHONE NUMBER: EMAIL: @

MEDICARE NUMBER: REFERENCE: EXPIRY DATE:

PARENT'S / GUARDIAN'S FULL NAME: MOBILE:

MEDICARE REFERENCE NUMBER: DOB:

OTHER PARENT'S / GUARDIAN'S FULL NAME: MOBILE:

MEDICARE REFERENCE NUMBER: DOB:

PRIVATE HOSPITAL COVER? YES NO FUND NAME: MEMBERSHIP NO:

HEALTH CARE CARD OR PENSION? YES CARD NUMBER: EXPIRY DATE:

OTHER CHILDREN SEEN PREVIOUSLY BY DR EE:

REFERRING DOCTOR: ADDRESS:

LOCAL GP (if different to above): ADDRESS:

All consultations incur fees, all fees are to be **PAID IN FULL ON THE DAY**, HCC/Pension Card holders will receive appropriate concessions.

This practice will collect personal information in order to provide an accurate medical diagnosis and appropriate treatment. This information is confidential and collected with your consent.

Patients who see Dr Ee in his private rooms but have surgery performed at **The Women's & Children's Hospital as a public patient** should be aware that their procedure **will be performed by training Registrars**, under Dr Ee's or an associated Specialist's supervision. Follow up after the surgery will be through the public sector unless otherwise arranged prior to surgery.

CONSENTS

- I provide my consent for Dr Ee to obtain any health information necessary for the accurate diagnosis and treatment of my child's condition.
- If surgery is advised as a result of our consultation with Dr Ee, I accept responsibility to find out all aspects of that surgery including risks, alternatives, possible complications and out of pocket expenses incurred before agreeing to any procedures.
- When booking surgery, the practice will charge a $150.00 administrative surgery booking fee at the time of scheduling the surgery.
- In the event that my account becomes overdue and the practice has to engage the services of a collection agency, I authorise the practice to provide the agency with personal information. I undertake to pay any collection fees incurred.
- Dr Ee may take pre-operative and post-operative photographs. These photographs remain property of the practice and may be used for patient information, teaching, medical presentation and/or publications. I provide my consent for these photographs with (please tick one);
  - ☐ No conditions
  - ☐ The following conditions (i.e. not for other patient information / not for journal publication)
  - ☐ Consent declined for taking of photographs

Parent/Guardian Signature: **Date:**