

Sydney South East Psychiatry

Shop 4/ 155 Avoca Street, RANDWICK NSW 2031
Fax: 02 8823 1843 or e-mail: info@sydneysepsychiatry.com.au

NEW PATIENT REGISTRATION FORM

Date: ____ / ____ / ____

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Surname: _____

Given Names: _____

Date of Birth: ____ / ____ / ____

Postal Address: _____

Postcode: _____

Phone number Home: _____

Mobile: _____ Work: _____

Email address: _____

Preferred method of communication: ☐ Phone ☐ Email

Occupation: _____

Emergency Contact Person: _____ Relationship to you: _____

Contact number: _____

GP Name: _____

Specialist Name: _____

Referred by: ☐ GP ☐ Specialist

What is the name of your referring doctor? _____

DVA: Gold Card ☐ White Card ☐ DVA Card Number: _____

Medicare Number: _____ Patient ID: ____ Exp Date ____ / ____

Do you have private health cover? ☐ Yes ☐ No

Health Fund _____ Membership Number _____

Does your insurance cover you for Private Hospital Admission? ☐ Yes ☐ No

Will this be an insurance or workers compensation claim? ☐ Yes ☐ No

PRIVACY STATEMENT

In accordance with the Privacy Act 1988 (Cth) and the Health Records and Information Privacy Act 2002 (NSW), all patients must provide written consent for the following aspects of their medical care:

- I agree to Dr Gordon Hyde taking a full medical history that relates to my medical condition and ongoing management.
- I agree that relevant information may be obtained from other medical practitioners (such as GPs and specialists), healthcare providers, pathology clinics, and hospitals as clinically necessary.
- I agree that Dr Gordon Hyde may discuss my medical history, diagnosis, and management with my referring GP and other relevant specialists in relation to my medical care.
- I understand that I may apply to access my health records, subject to any exceptions provided under relevant state and federal legislation.

Patient Signature: _____

Date: ____ / ____ / ____