OBSTETRICS &
GYNAECOLOGY

Dr Jason Chew
MBBS(Hons), FRANZCOG

Patient Registration Form

Title **Miss / Ms / Mrs / Dr**	Surname	Given Name	Known as
Date of Birth		Home Address	
Marital Status			
Occupation		Work Address	
Employer			
Phone	Home	Work	Mobile
Email			
Medicare	Medicare Number	Position on Card	Expiry Date
Private Health Insurance? **YES / NO**	Health Fund	Membership Number	Pensioner Number DVA Number
Next of Kin	Surname	Given Name	Relationship
Phone	Home	Work	Mobile
General Practitioner			**Referring Doctor?** **YES / NO**
Practice Address			

Mitcham Rooms
29 Doncaster East Road,
Mitcham 3132
Tel: (03) 9874 2333
Fax: (03) 9874 2444

Box Hill Rooms
Level 3, Suite 307, 116-118
Thames St, Box Hill 3128
Tel: (03) 9890 5999
Fax: (03) 9899 3211

Knox Rooms
Shop 2/680 Boronia Road,
Wantirna 3152
Tel: (03) 9800 5111
Fax: (03) 9800 5211

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Privacy Statement

We need your consent to collect information about you.

The information we may ask of you is deeply personal.

This statement explains what your rights are over the use of the information we are entrusted with in order to provide you with the standard of medical care that you expect.

As a patient of the practice, you consent the practice to collect personal information about you. The information is used primarily for providing medical care. This includes disclosure to others involved in your health care, including clinical practitioners outside of this practice who may become involved in your care. Your personal information is also required for administrative, billing and compliance with Medicare and Health Insurance Commission requirements.

We are committed to respecting your confidentiality and preserving your privacy. Our staff will keep your personal information secure and protected from unauthorised access or improper use, and we will only disclose information about you if it is authorised by you or mandated by law.

Patient Acknowledgement

I have read and understood the privacy policy of this medical practice.

I consent to the handling of my information by this medical practice for the purpose set out above.

Signed …….. ***Date: ……..***

Name: ……

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