

**DR ANDREW TEICHTAHL (MBBS (Hons), B.Physio (Hons), FRACP, PhD)**  
**RHEUMATOLOGIST**

*Confidential Patient Registration Form*

**Surname:**

**Given Name (name on Medicare Card):**

**Title: Mr. Mrs. Miss. Ms. Dr. Rev \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_**

**Home address:**

**Suburb: State: Postcode:**

**Home Ph: Business Ph: Mobile Ph:**

**Email:**

**Medicare No: \_\_\_\_\_ Ref No \_\_\_ Expiry \_\_\_/\_\_\_**

**Private Health Fund Provider: Membership No:**

**Are you on a full pension, DVA or Health Care Card? Yes/No**

**Customer Reference Number: Expiry date:**

**Next of Kin contact name:**

**Relationship to patient:**

**Next of kin contact phone:**

**Referring Doctor:**

**Doctor Contact details:**

**Usual GP details (if different to above):**

I, \_\_\_\_\_ (please write in capitals)

Authorise the release of my relevant medical records to:

Dr Andrew Teichtahl 46 Heatherton Rd, Endeavour Hills Vic 3802 Ph: 9700 7666 Fax: 9700 5952

**Signed: Date:**

**Dr Andrew Teichtahl**  
**MBBS (Hons), B.Physio (Hons), FRACP, PhD**



**All bookings and correspondence:**  
46 Heatherton Road, Endeavour Hills, 3802  
Phone: 9700 7666  
Fax: 9700 5952

Consulting at

Knox Private Hospital (Mon)  
Wellness on Wellington (Tue)  
Heatherton Road Specialist Centre (Wed)

Blackburn Specialist Centre (Tues/Sat)  
Manningham Consulting Suites (Thurs)

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## PRIVACY STATEMENT

Arthritis & Rheumatology Centre collects personal information from you for the primary purpose of providing quality healthcare. We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide to this practice in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice
- This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. 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 some circumstances where access might legitimately be withheld, I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

**I understand that I will incur a cancellation fee of \$50 if I cancel my appointment without 24 hours prior notice (apart from exceptional circumstances).**

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.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

Full name of patient \_\_\_\_\_